UNIVERSITY OF DERBY

DISCIPLINARY UNDERSTANDINGS OF ANOREXIA NERVOSA:

ART THERAPY AND PSYCHIATRIC RESEARCH FROM A FEMINIST PERSPECTIVE

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Doctor of Philosophy 2011

UNIVERSITY of DERBY

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Abstract

This dissertation explores the constructed nature of the concept of anorexia nervosa in the disciplines of art therapy and psychiatry and considers the ramifications of this on the way women are constructed. This dissertation consisted of three new studies of the construction of anorexia nervosa within disciplinary discourse: 1) a corpus of research articles in psychiatry in 2009; 2) an analysis of the DSM IV and proposed revisions to this document for the future DSM V; and 3) a comprehensive, analysis of the construction of anorexia in all the published research with the field of art therapy. This study offers the first poststructuralist genealogy of the construction of anorexia nervosa in the field of art therapy and the way disciplinary discourse works in that field. Furthermore, this research extended existing poststructuralist studies of anorexia nervosa into the 21st century by carefully considering psychiatric literature in 2009 and the proposals for the revision of the DSM V.

The main findings of this dissertation reaffirm the concept that anorexia nervosa is a constructed term resulting from discursive, disciplinary forces. As found here, the discourse of psychiatry was found to be in a power struggle with other disciplines and have asserted its power through adherence to Neo-Kraepilianian guidelines and the reinvention of the DSM. There was a preference for the medicalization of anorexia nervosa and to see it as natural disease and genetic predisposition as well as an increase in the usage of the categories of cognitive dysfunction and body image distortion. The art therapy literature moved from psychodynamic disturbance and familial pathology to cognitive dysfunction and body image distortion explanations. In addition, for art therapy at the end of the 20th century and into the 21st century there was some exploration of socio-cultural context and spiritual explanations of anorexia nervosa. Overall the construction of women in the art therapy literature on anorexia nervosa moved from explicitly negative characterizations of women built upon accusatory narratives and personal flaws to more subtly hidden negative descriptions.

In the psychiatric literature of the 21st century and the proposed revisions of the influential DSM V there is a preference for biological and behavioural understandings of anorexia that neutralize gender and distance socio-cultural explanations. The gendered and socio-cultural understandings of anorexia nervosa are being actively distanced from the explanation of anorexia nervosa. This is highly problematic as there is quite obvious and empirically validated evidence positioning anorexia nervosa as a gendered, socio-cultural phenomenon and this way of understanding allows new options for treatment.

Acknowledgements

Writing a dissertation can only be achieved through the help of others. Accordingly, there are several people I would like to thank for their contributions to this project. First, I would like to thank my dissertation director Prof. Susan Hogan. Prof. Hogan introduced me to feminist research and feminist art therapy. Through her scholarship, feedback and interaction she opened a new world for me and provided me with the tools to transform my sense of self and the way I work in my clinical practice as an art therapist. This dissertation would not have been possible without the continued support and rigorous reading of my work by Prof. Hogan.

I thank my local advisor in Pittsburgh, Dr. Annie Preis for her continual support during the five years of writing this dissertation. Dr. Pries supported me both psychologically and academically. Dr. Preis's positive comments and her sensitivity to cultural and linguistic differences truly helped me through the difficult task of writing a dissertation in a second language.

I thank my committee member Prof. Brannigan for his support at the beginning of this dissertation and his balanced advice throughout this process. I also thank Prof. Paul Weller for his warmth and ability to create a sense of belonging to the University of Derby during the long and rather lonely process of writing a dissertation at a distance. I also want to thank my friend and colleague Dr. Caroline Simone for her advice, support, encouragement and practical help in completing this dissertation. I thank my readers Dr. Debra Gimlin and Dr. Jane Montague for their insightful comments and interesting discussion of my research.

I thank my family for their support, love and patience. I am happy that the work on this dissertation opened a channel of communication that contributed to our family understanding of gender, power relations and culture and their role in our lives.

Special thanks to Charlie, just for being there.

Chapter One

Understanding Anorexia Nervosa: A Feminist, Poststructuralist Approach

1.1 Basic Positions

My interest in researching the phenomenon of anorexia nervosa emerged from my fifteen years of clinical experience as an art-psychotherapist working with women diagnosed as having anorexia nervosa and my frustration with current understandings that exist in the field of mental health concerning these women. The personal importance of this project was further fuelled by my knowledge of the persistence of this phenomenon, the difficulty in treating these women and the rapid growth of the numbers of women who are suffering from self starvation. As a clinical art-psychotherapist I have worked with women patients diagnosed as suffering from anorexia nervosa in private practice, in in-patient and out-patient hospital settings in Israel and the US. Within the settings I have worked I have observed and experienced how these women are constructed in medical discourse and the limitations and accusations that this involves. Furthermore, I have seen how the different disciplines involved in treating these patients are positioned in different ways and the power relationships that exist among them. The patients at the heart of this dissertation – women who starve themselves to death – are ultimately my central concern and this dissertation is an attempt to explore disciplinary, discursive context that constructs them and to offer a different theoretical orientation to explain what they are suffering from.

This dissertation, like my former MA Thesis conducted at Hahnemann University in Philadelphia, attempts to understand the phenomena of anorexia nervosa. However, as opposed to my previous attempts which utilized qualitative research methods, the current study employs a very different approach. As will be discussed in detail in the first three chapters of this dissertation, this study is poststructuralist and feminist in orientation and as such addresses new ways of investigating and understanding anorexia nervosa in the field of art therapy. This dissertation is an attempt to explore the understanding the concept of anorexia nervosa and to consider the ramifications of this concept on the way women are constructed. The study is poststructuralist and feminist and as such takes a very particular orientation towards how this research was conducted. The data for this study consisted of published research materials which were analysed using critical, historical discourse approaches. An important aspect of this dissertation is the importance attached to the idea of discipline as an organizing factor in

discourse. Specifically the current study explored the way anorexia nervosa was constructed within the disciplines of art therapy and psychiatry. This process involved the description of the disciplinary guidelines of art therapy and psychiatry and the way these understandings directed the construction of anorexia nervosa in these fields. This dissertation is different from others developed within the field of art therapy in that it develops the first poststructuralist genealogy of the construction of anorexia nervosa in the field of art therapy and the way disciplinary discourse works in that field.

1.2 A Microcosm of this Dissertation

As a way of introducing this dissertation, I would like to start with two quotes which come from very different sources but deal with the same theme – an attempt to define anorexia nervosa. The discussion of these quotes provides a brief microcosm of the dissertation as a whole and a way of introducing the main ideas, aims, theoretical orientations, research questions and theorists involved in this study.

> **"Diagnostic criteria for 307.1 Anorexia Nervosa**
>
> A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
> B. Intense fear of gaining weight or becoming fat, even though underweight.
> C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.
> D. In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g. estrogen, administration.)
>
> *Specify* type:
>
> - **Restricting Type**: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas)

- **Binge-Eating/ Purging Type:** during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas)" (American Psychiatric Association, 1994, pp. 544-545).

> "From the analysis of an image that I have found recurrent among anorexic patients, and that I have called a double trap. I suggest that the internal world of anorexic patients – or at least a subgroup of them – is characterized by the co-presence of more than one negative object of a persecutory nature and by the absence of an internalized containing good image. This makes the external world very frightening and the patient seems to have taken the decision of a defensive immobility as the only position that allows survival." (Luzzatto, 1994, p. 142)

These two quotations come from very different sources. The first, produced by a professional task force consisting of established psychiatrists from the American Psychiatric Association and published in the widely distributed *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, is arguable the most cited definition of anorexia nervosa in published academic literature. The second quotation, produced by an art therapist and published in the journal *Arts in Psychotherapy*, is known to a small group of practicing and publishing art therapists who deal with eating disorders in their clinical and research practices but is rarely, if ever, quoted in any academic literature on anorexia nervosa beyond this group. The comparison of these two quotations is a microcosm of this dissertation as a whole and as such, perhaps may serve as a good introduction into the issues at the heart of this dissertation.

So what can be said about these quotations? First of all both of these quotations aim to describe an aspect of the phenomenon of self starving women termed within the medical literature as anorexia nervosa. In this sense each of these quotations is part of a rather large body of published academic literature that aims to explain, describe, understand, clarify and explicate the nature of this phenomenon. On a very basic level, each of these quotes is part of an attempt by a range of professionals (such as researchers, doctors, administrators, teachers, social workers, psychiatrists, psychologists, expressive art therapists…etc.) to understand, treat and perhaps prevent the phenomenon of self starving women. The aim, described in this way, is admirable especially since the latest statistics on the frequency and dangers of anorexia show that

in Western and Westernized countries1 in 200 girls of the age of 16 has anorexia, that in the US it is the most prevalent mental disorder leading to inpatient care and, most importantly, as reported in the UK, anorexia nervosa has the highest mortality rate of any psychiatric disorder (Gowers, *et al.*, 2010). The phenomenon of self starving girls has very serious physical, social and psychological outcomes and as such has spawned significant interest from all types of mental health professionals.

Furthermore, the vision of the emaciated bodies of anorectic patients reminiscent of Holocaust survivors from the concentration camps after the Second World War and the idea of girls starving themselves to death has captured both media attention and more broadly the imagination and, to a certain extent, the fascination of the public (Allen, 2008). It seems to defy the logic of a society built during the 20th and 21st centuries on consumerism and the presence of plenty. The phenomenon of girls denying themselves food also seems to be counter to the basic survival drives of life. The presence of self starving girls visible killing themselves through the restriction of food poses a very real enigma in societies which have spent centuries solving the problem of making food abundant and cheap. The visual and behavioural manifestations of anorexia nervosa has led to wide spread interest in this phenomenon and ultimately in the production of extensive popular and semi-professional literature in addition to the academic literature of professional bodies and researchers. Thus, anorexia nervosa for both professional and cultural reasons has become a topic of interest and has generated a vast literature of description and explanation.

The two quotes at the beginning of this chapter are part of the professional aspects of this wide literature on anorexia nervosa; however, it is quite clear from the comparison of these two quotes that they approach the task of describing anorexia in very different ways. The first quote provides diagnostic criteria and is set out as a series of points for patient evaluation. The language of the quote, true to its purpose of providing evaluative criteria, is authoritative and impersonal. The criteria are stated in unequivocal terms with the attempt to seem to be as accurate as possible. Specifically, the criteria focus on observable, measureable aspects of anorexia nervosa and with an emphasis on the physical aspects of this phenomenon such as weight loss and amenorrhea. According to this quote, anorexia nervosa is defined according to four basic criteria: low weight, fear of gaining weight, distortion in the perception of body weight and size and amenorrhea. The presence of these four evaluative criteria is further

augmented by the specification of two types of behaviour leading to weight loss: food restriction and forced food purging. Anorexia nervosa is situated in the individual patient and is seen as consisting of this specific set of features. The presented understanding of this quote (as manifest in the introduction to the DSM IV) suggests that the definitions provided result from an extensive review of a large body of research by designated psychiatric researchers and this adds authority to this specific definition.

The second quote also defines features of anorexia nervosa, but is based on a very different position. This quote is from a research paper published in a respected art therapy journal and consists of the main finding (and ultimately the conclusion) of a study of anorexic patients. The object of observation is not the anorexic patient but rather a collection of paintings made by these patients. As stated in this quote close observation of a series of paintings by anorexic patients revealed the presence of a recurrent image. This image thus becomes a defining feature of the anorexic patient and a source of insight into the nature of the internal world and state of the anorexic girl. Specifically, the internal emotional state of the anorexic girls who produced these images is described as consisting of a sense of persecution and fear of the outside world. Referencing theories from object relations psychology, this sense of persecution is explained as a result of the internalization of a negative object and the absence of good object both (although not explicitly stated here) aspects and results of early mothering practices. The anorexic girl suffers from the presence of multiple persecutory objects and no way of protecting herself. Hence she suffers from fear of the environment and feels persecuted. The image described by the researcher is termed the "double trap" and describes a situation of being immobile as a survival strategy. The assumption is that the physical act of self starvation is tied to the internal state of immobility, persecution and fear described through images of entrapment. The emphasis in this description is on the psychological states and unconscious embodiments that can be inferred from the images produced by these anorexic patients to their internal world. This definition of anorexia does not look at explicit behaviours or physical markers; but rather is focused on emotional states and developmental psychodynamic mechanisms that can be inferred from the analysis of produced images by anorexic patients. Notably, the researcher uses the first person pronoun "I" to specify that these are her conclusions and that these result from her analysis of her own patients art work. Overall, this quote situates anorexia nervosa within the

psychological and emotional internal state of the anorexic girl resulting from early developmental experiences.

As a quick comparison, several very clear differences can be noted between the two quotes. First the object of description is different between the two quotes. The quote from the DSM IV looks at the body, behaviour and cognition of the anorexic girl and bases it description on these aspects. The quote from an art therapy research paper focuses on emotional and psychodynamic states and describes the internal state of the anorexic girl and bases its description on that. Second, the source of data is different between the two quotes. The description of anorexia in the DSM IV comes from a meta-analysis of psychiatric literature (none of which is actually presented) and offers a form of interpretive summary of this data. The art therapy quote is based on the close analysis of specific pictures produced by anorexic patients in the researcher's care. Thirdly, the tone of the two quotes is very different. The psychiatric quote is authoritative and unequivocal as if it is stating a collection of facts. The art therapy quote clearly specifies the personal nature of the specific interpretation of the analysed data of anorexic art work. Finally the status of each of these quotes is very different. The quote from the DSM IV is widely disseminated and quoted. There are very few professional papers on anorexia nervosa that do not explicitly address the psychiatric definition of anorexia nervosa as it appears within one of the versions of the DSM. The quote from the art therapy literature is only quoted in other art therapy research papers. Thus the impact of the quote from the DSM IV, as evaluated by the number of times it is referenced by other professional literature far outweighs that of the art therapy explanation. Furthermore, even within the popular literature and media it is the quote from the DSM that is presented as authoritative professional knowledge.

So what does this comparison of these two quotes tell us about anorexia nervosa? Well on a simple level, it is obvious that there are different ways of describing anorexia nervosa and different methodologies for doing this. Basically, the difference between these quotes can be assigned to the fact that they come from different sources and are designed to fulfil different purposes. The first quote is designed for psychiatrists and was produced within a book that is used as a diagnostic handbook. The second is from a research article read by art therapist researchers and serves as a summary of findings based on the analysis of art work from anorexic patients. Thus, as an initial hypothesis, disciplinary context would seem to be important. The fact that the first quote comes from the central US organization of psychiatrists and the second comes

from a practicing art therapy researcher and that each of these is designed for its particular group of readers directs a process in which the quotes have very particular linguistic and conceptual formats. One is presented in an authoritative voice and looks for explicit sources of evidence; the other is presented as personal interpretation and infers explanations of internal psychodynamic and emotional states. While I have only presented two quotes here, the principle I am suggesting is that rather than seeing these quotes as examples of individual writer difference they are actually examples of disciplinary differences. I am aware that it is a logical flaw to extrapolate from such a small sample of two but as an introductory microcosm of this dissertation, the principle I am presenting is that *disciplinary discourse has a central influence on the way the anorexia nervosa is understood.* In fact the actual term anorexia nervosa demonstrates the power of certain discourses as this medical term with a very specific history has come to represent (and explain) the phenomenon of self starving women (Malson, 1998).

There is another very basic idea that evolves from the brief comparison presented at the beginning of this chapter – *there can be very different explanations of anorexia nervosa.* In other words, as opposed to the lay perception of a single agreed upon explanation of the phenomenon of self starving women, it would seem that there are different ways in which this phenomenon is explained. This in itself raises the question as to how will different interested parties decide which definition and description to use in their personal lives or clinical work? In other words, the presence of different ways of explaining the phenomenon of self starving women creates a situation in which there is potentially a power struggle in which different explanations compete for dominance. It should be noted that the question of which definition of anorexia reigns supreme is not an idle academic concern as people's lives may rest upon constructing an appropriate definition and within the economic and legal world of medical decisions the status and access to treatment may depend on the way this phenomenon is described.

There is a further simple conclusion that arises from the comparison of these two quotes – *the concept of anorexia nervosa has been constructed.* In other words, since the descriptions are so different, based on different objects of observation, expressed in different ways and utilizing different methodologies to reach their conclusions, it is clear that the concept of anorexia is constructed in different ways. This questions any simplistic assumption that these definitions are just different approximations of the reality of self starving women. The differences in these quotes do not result from differences in a real world but rather from looking

at different aspects of the phenomenon and reaching conclusions based on these ways of looking. Furthermore, once a concept has been constructed, propagated and accepted it has power in itself to reconstruct how individuals view the world. To describe self starving women as anorexic is an act of description that brings with it all the work that has gone into constructing the concept of anorexia. This aspect of the constructed nature of anorexia nervosa further enhances the presence of a power struggle in relation to which definition will become the accepted norm.

If discipline is a major factor in the construction of knowledge then different bodies of literature from different disciplines would actually describe this phenomenon in different ways. Thus, potentially as an initial hypothesis, discipline would have a directive role in constructing knowledge. A subsequent hypothesis would be that for each discipline there could be types of explanation that are not valued or admitted into the explanation. One of these potential omissions is of particular interest to the current dissertation. Current statistical data states that there is a ratio of 11 females for each 1 male sufferer of anorexia nervosa (Gowers, *et al.*, 2010). This would suggest that there is a gendered aspect to the phenomenon of self starvation. Furthermore it is predominant in a particular type of socio-cultural context – Western (and Westernized) societies and most prevalent around the ages of adolescence. Thus not only does it seem to be a gendered phenomenon but also a social-cultural and age related phenomenon as well. While the statistical data is clear on this issue, the gendered, social-cultural nature of this phenomenon does not seems to have had much influence on the explicit description of anorexia nervosa as it appears in these two quotes.

Ironically perhaps, the two quotes presented above do agree that these girls are fearful. In one case they are scared of gaining weight and fat; in the other case they are scared of being persecuted in their environment. The two quotes also are in agreement that the phenomenon of anorexia nervosa is situated in the individual patient. Neither of these quotes enters into an explanation of the relationship of gender, fear and the social cultural context. Interesting the rhetorical strategy of these two quotes is different in relation to this issue. In the psychiatric quote, the issue is avoided all together using what can be called a distancing strategy. Fear is referenced but it has a disembodied aspect to it, as if these girls of their own volition suddenly became fearful of becoming fat. There is no context or explanation of this fear. For the art therapy quote the rhetorical strategy used is that of narrative construction. The fear of these girls

is reconstructed within a developmental narrative of early childhood experiences (with inferences to theories that directly blame mothers).

At the beginning of this section, I said that the comparison of these quotes offered a microcosm of this dissertation. So having presented these two quotes and entered into some initial discussion and analysis of the issues involved, let me summarize what can be learnt from this comparison and then in the next section enter into a discussion of how this relates to the current study. By comparing these two quotes, several main points emerge in relation to my understanding of anorexia nervosa. First, my argument has been that the differences between these quotes do not result from individual differences between the writers but rather are a result of the disciplines within which they were written. Second I have argued that there are different ways of constructing anorexia nervosa and that this leads to a situation in which there is potentially a power struggle over which definition of anorexia nervosa will be accepted and used in the social realm. Third, I have argued that the concept of anorexia nervosa is a constructed term that is used to cover and explain the phenomenon of self starving women. Fourth, I have argued that the constructed nature of the concept anorexia nervosa means that certain information is included while other types of information are avoided. Finally, I have argued that the gendered and socio-cultural aspects of anorexia would seem, on the basis of statistical data to be significant, but in the two specific cases dealt with in this first section to have been omitted from the description of anorexia nervosa. These arguments when taken together produce a very particular orientation towards the phenomenon of anorexia nervosa – an orientation that situates the understanding of anorexia nervosa within a discussion of the literature that is used to construct the concept of anorexia nervosa.

1.3 The Philosophical Orientation and Aims of this Dissertation

The analysis that appears above in relation to the two quotes defining anorexia nervosa did not develop in a vacuum or as the result of 'brilliant' individual thought; but rather it is the result of exposure to a series of philosophical and methodological perspectives which orientate my understanding and presentation of these quotes. In other words, my analysis is informed by a series of related philosophical orientations and the aim of this section is to explain briefly the nature of these orientations and to state explicitly the aims of the current dissertation in relation to the issue of self starving women. I would argue that understanding the aims of this dissertation

requires an understanding of the philosophical orientation that informs it and thus both of these appear within this introduction to my dissertation project.

In theoretical terms, the analysis that appears above addresses three well known and heavily theorized concepts – language, power and gender (Alvesson & Skoldberg, 2000; Lazar, 2005; Speer, 2005). While the specific object of my discussion is the understanding and definition of anorexia nervosa, an aspect of mental illness discourse, the overall orientation, topic of discussion and methodology is based on these three underpinning foci. In this sense the philosophical orientation of this dissertation can be defined as embodying a *feminist, poststructuralist approach.* It is poststructuralist in the sense that language in this study is understood in very particular ways. In alignment with poststructuralist thought, I reject realist assumptions concerning language as having the ability to accurately reflect and mirror reality (Ricoeur, 1974, 1981). Language is seen as formative and directive rather than reflective. Language constructs our understanding of the world rather than just reporting on any reality that exists independently of language. Accordingly, the quotes above are not just different appropriations of reality but rather are attempts to construct the world in very specific ways. There are many diverse and different understandings of the concept of poststructuralism and it is not my aim here to review the range of options. At this point in the dissertation it is enough to point out that the importance of poststructuralism to this dissertation is the idea that language is formative and largely self referential creating a large network of ideas and concepts that are propagated through language. Accordingly, the study of the meaning of a concept such as anorexia nervosa involves a study of the ways in which this concept is constructed in discourse and its associated representational systems.

The concept of power which informs this study borrows heavily on the ideas propagated and explored by the poststructularist, cultural historian Michel Foucault (1978, 1979, 1980, 1982). Power is seen as inherently tied to issues of knowledge. From a Foucauldian perspective knowledge constitutes power and as such any discussion of knowledge construction is simulatanously a discussion of power relations. As imagined by Foucault power is not an object and does not function in a uni-directional (top-down) mode. Power is fluid, multidirectional, situated in discourse and involvies a constant struggle of social relations. As seen briefly in the case above the definition of anorexia nervosa is not an abstract concern of researchers but rather embodies the power struggle between various groups within a much wider social realm. There is

a further debt to Foucault's research that is apparent in the analysis of the quotes above and that is that knowledge is formed within very specific discourses of power (Foucault, 1972). In the present case, the discourse of interest is disciplinary. Accordingly, from a poststructuralist Foucaldian perspective, the exploration of the way the concept of anorexia nervosa is understood involves an analysis of the way this concept is constructed in particular disciplinary contexts and a consideration of the power relations inherent to these ways of constructing meaning.

An aspect of the definition of anorexia nervosa is the way in which this may have ramifications on the construction of women. From a poststructuralist feminist perspective the concept of gender is a constructed and changing entity that is influenced by the multiple contexts within which it is constructed (Alvesson & Skoldberg, 2000; Hogan, 1997). For this dissertation, the exploration of the concept of anorexia nervosa involves a consideration of the way women are constructed as well. A different feminist aspect of this study is the idea that gender is a varaible that needs to be addressed in all forms of psychological and social research (Hogan, 1997; Lazar, 2005). In the present case, as referenced above, there are very good statistical as well as ideological reasons for emphasizing the gendered aspects of anorexia nervosa. But beyond looking at gender as a variable and a constructed entity, this dissertation is also formulated within what Alvesson & Skoldberg (2000) define as an "emancipatory knowledge interest" (p. 215). In other words, one of the aims of this dissertation is to enhance clinical pratice within the field of art therapy and in relation to the phenomenon of self starving women. I, like other researchers who address anorexia nervosa, wish to help these women to survive, enhance their quality of life and understand their own experiences.

So having briefly touched upon the broad philosophical orientation of this dissertation and provided a short example of the issue under discussion – the construction of anorexia nervosa – it is time to provide a succinct statement of my aims. The aim of this dissertation is *to explore the constructed nature of the concept of anorexia nervosa in the disciplines of art therapy and psychiatry and to consider the ramifications of this on the way women are constructed.* In other words, as with the two quotes that appear at the beginning of this chapter, this dissertation as a whole will explore the disciplinary construction of the concept of anorexia nervosa and compare between disciplines. Specifically, the study will investigate published academic materials that aim to define anorexia nervosa in the fields of psychiatry and art therapy. Furthermore as defined in the feminist concept of "emancipatory knowledge interest" the aim is

to further understand how gender informs and is informed by definitions with the fields of mental health and to critically interact with these definitions in order to facilitate the further development of feminist art therapy practice with self starving women.

1.4 Research Questions

As stated above, this dissertation aims to explore the disciplinary construction of anorexia nervosa and the associated construction of women within the disciplines of art therapy and psychiatry. The study addresses disciplinary texts and is organized around the following specific research questions.

1. How is the phenomenon of self-starving women (termed anorexia nervosa) explained by prominent researchers within the disciplines of art therapy and psychiatry?
2. In what ways does the discourse inform and constrain the production of disciplinary explanations of the phenomenon of self starving women (termed anorexia nervosa) within the fields of art therapy and psychiatry?
3. In what ways are women constructed and represented within the predominant explanations of the phenomenon of self starving women (termed anorexia nervosa) within the disciplines of art therapy and psychiatry?
4. What are the implications for art therapy practice? How might art therapists modify their work in the light of the findings?

1.5 Personal Influences on the Development of this Dissertation

Before I end this chapter with an outline of the structure of this dissertation, I would like to situate my study in relation to some major personal influences on my work. There are some obvious precursors to a study of this type and they need to be mentioned as seminal studies without which my own dissertation project would not have been possible. While there are many texts that have informed my work, three researchers and more importantly their extended research projects are of central significance and I wish to mention them directly as a personal context for the development of this dissertation. The three researchers are Michel Foucault, Helen Malson and Susan Hogan. As will be seen in the outline below and in the coming chapters, each of these three researchers has made a major contribution to the way this dissertation was conceptualized, conducted and written.

Foucault's contribution to this study was indirect but crucial. The idea of exploring the historical construction of a concept within the context of disciplines and to address medical,

psychiatric discourse is inherently a Foucauldian set of ideas. Early in the process of preparing for this dissertation, I read Foucault's (1976 originally published in 1954) *Mental Illness and Psychology* in which the following research aim is stated: "I would like to show that the root of mental pathology must be sought not in some kind of "metapathology," but in a certain relation, historically situated, of man to the madman and to the true man" (p. 2). This early work by Foucault attempts to differentiate mental disease from physical disease and, most importantly, situates the study of mental disease as a cultural phenomenon. The research agenda is designed to explore how socio-cultural concepts of normativity are constructed and utilized to assign meanings to madness. This work is part of a very well known, extended research project that ultimately explored the cultural-historical construction of otherness in the form of mental disease, prisons and sexuality. This extended research project explores the workings of power within social realms and the intricacies of the power/knowledge relationship. While I in no way claim to be an expert on Foucault, his conceptualization of inquiries into mental health issues facilitated the research project presented in this dissertation as will be clearly seen and explicitly discussed in Chapters Two and Three.

Foucault's research also contributed to the development of the provisional socio-cultural theory of self starving women that appears in the postscript of this dissertation. The idea that control in modernity is enacted through the construction of a self-regimenting consciousness in the individual explicated in Foucault's (1979) discussion of the Panopticon, is the starting point for the proposed theory. Foucault's contribution here was to provide a theoretical description of the phenomenological state of the modern individual and the specific idea that modernity aimed to produce "docile bodies" through the internalization of external gaze. Foucauldian theory was both critiqued and developed through the work of the feminist theorist Bartky (1990) into a theory of the consciousness of women which offered a basis for the development of my own theoretical understanding self starving women. As such Foucault's work started a chain a thought that allowed me to develop a gendered, social-cultural theory of self-starving women that appears in the last chapter of this dissertation.

More directly than Foucault, in many ways this dissertation has been helped by the seminal work of two feminist researchers: Helen Malson and Susan Hogan. One of the criticisms of Foucault is that he did not pay enough attention to issues of gender (Malson, 1998; McNay, 1992) and it is through the work of Helen Malson, a poststructuralist, and feminist psychology

researcher, that I learnt how to relate Foucault's ideas to the issue of the construction of anorexia nervosa and issues of gender. As conceptualized by Malson (1998) a Foucauldian, poststructuralist approach

> "enables a critical questioning of the 'mainstream' conceptions of 'anorexia nervosa' and which facilitates a mode of enquiry that more fully locates 'anorexia' within its socio-cultural, discursive contexts. It enables an exploration of the discourses in which anorexia, femininity, subjectivity and the body are discursively constituted and regulated. It enables an exploration of the ways in which the micro-physics of power that functions in discourse operates upon the female and the anorexic body" (p. 44).

Malson's (1998) study of the construction of anorexia nervosa within the disciplines of psychiatry and psychology facilitated my dissertation by providing theoretical tools, methodological practices and research outcomes that informed my own work. In particular, Malson (1998) outlined a taxonomy of the ways in which anorexia nervosa has been explained (and subsequently constructed) in the professional literature of psychiatry and psychology. As will be seen throughout this dissertation (but especially in Chapter Six), Malson's (1998) research is fundamental to my own and I thank her for it.

Finally my own development as an art therapist researcher has been directly informed by the work of Susan Hogan who introduced me to, directed me and facilitated my understanding of feminist art therapy. I have worked for many years as an art therapist who has treated patients' who suffer from anorexia both in Israel and the US and it was quite natural for me having completed my MA that analysed the art work of girls diagnosed as having anorexia nervosa to continue my research in this direction. My therapeutic practice and clinical research was based on theories found within the realm of psychodynamic research employed into the field of art psychotherapy and as will be seen in Chapter Six, my academic publications on this issue described anorexia nervosa within this theoretical frame. Hogan's work, and especially her (1997) edited volume entitled *Feminist Approaches to Art Therapy*, opened up a new way of seeing art therapy through the perspective of feminism. Hogan's (1997) concept that "an individual's sense of sorrow, loss anger, marginalization and oppression, or her embodied experiences of disability, impairment, abuse, pain or illness are not simply personal' (p.8) facilitated my understanding of the socio-cultural context of women's mental health.

Furthermore, Hogan (1997) explicated the role of therapeutic art work within this context when she stated that "the art-therapeutic process must be capable of enabling women to understand, question and challenge the social and cultural conditions which are responsible for definition as 'mad' or 'deviant'" (p. 38). These ideas led to significant changes in my understanding of art therapy practice with girls who suffer from anorexia which are discussed and summarized in the last chapter of this dissertation Chapter Ten. In relation to the topic of this dissertation, Susan Hogan's (1995,1997, 2001) historical-cultural research that explored the role of visual representation and the positioning of women within the medical discourse functioned as an important precursor to the project presented in this dissertation in relation to construction of anorexia nervosa within the field of art therapy. Thus on the conceptual, methodological and practical levels, Hogan's research has been central for this dissertation.

1.6. An Overview of this Dissertation

This dissertation is organized in four different sections: theory, method, results, conclusions and ramifications. The first part of the dissertation, Chapters Two and Three develop the theoretical and methodological orientation of this dissertation. Chapter Two presents the conceptual understanding of disciplinary discourse and power that underpins this research project. Utilizing theoretical understandings from both Foucault (1972) and Malson (1998), a specific case of the interaction between psychiatry and art therapy over the investigation of anorexia nervosa is explicated and the inherent power relations between these disciplines is discussed. This is the theoretical basis upon which the comparison of the development of anorexia nervosa in the fields of art therapy and psychiatry is justified. Chapter Three furthers the theoretical aspects of this dissertation by developing a feminist, critical discourse analyst approach to written and visual representations. Through a review of critical discourse analysis, feminist discourse analysis and feminist approaches to visual representation, the methodological aspects of this study are explained.

Chapter Four summarizes the research method used in this study of the disciplinary construction of anorexia nervosa. Based on the theoretical work developed in Chapters Two and Three, the proposed research methodology consists of a modified form of critical feminist discourse analysis that looks at verbal as well as visual representations of anorexia nervosa within published academic literature in the disciplines of art therapy and psychiatry.

The results of this study are presented in Chapters Five, Six, Seven and Eight. Chapter Five analyses the way psychiatry has constructed its discursive power base. The analysis is both historical and theoretical and explicates psychiatry's discourse of power as resulting from the way scientific discourse is employed in relation to the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Chapter Six provides a poststructuralist and historical review of the construction of the concept of anorexia nervosa as well as presenting new evidence relating to the way anorexia nervosa and women are constructed within the discipline of psychiatry in the 21st century. The chapter presents the findings of two studies of collected corpuses of psychiatric materials. The first study examines the types of explanation used in all the articles published concerning anorexia nervosa in three major psychiatric journals during the year 2009. This data updates the analysis conducted by Malson (1998) presented in earlier sections of the chapter. The second study explores a series of articles published by leading psychiatrists involved in the current revision of the definition of anorexia nervosa that will appear in the new version of the DSM. This second study offers direct insight into the way knowledge is currently being constructed in relation to the concept of anorexia nervosa by leading psychiatrists.

Chapters Seven and Eight present the findings concerning the construction of anorexia nervosa in the field of art therapy. Chapter Seven critically reviews the complete corpus of research papers of individual art therapists who have researched anorexia nervosa. The chapter provides historical evidence on the construction of the concept of anorexia nervosa within the published literature of art therapy through an analysis of the ways in which the actual art work of self starving women is understood and positioned. This chapter involves a detailed and critical analysis of a corpus of materials from specific art therapists who have presented and explained art work from female patients with anorexia. Chapter Eight presents the first analysis of the disciplinary discourse of art therapy and the ways in which anorexia nervosa and women are constructed in this discourse. This chapter which builds upon the individual reviews and analyses presented in Chapter Seven and aims to construct an understanding of disciplinary discourse in the field of art therapy and the ways in which this discourse constructed the concept of anorexia nervosa. The chapter provides a historical overview of the field of art therapy and the development of the concept of anorexia.

Chapter Nine provides a succinct summary of the main findings of this dissertation and the ramifications of this dissertation for the field of art therapy and the treatment of anorexia nervosa. The main findings address: the disciplinary discourse of art therapy; the disciplinary discourse of psychiatry; charting the interdisciplinary relationship between psychiatry and art therapy; the construction of anorexia nervosa; the construction of women in the art therapy literature on anorexia nervosa; the definition of anorexia nervosa in the 21st century; and the avoidance of gendered and critical socio-cultural understandings of anorexia nervosa. The main ramifications of the study for art therapy are 1) addressing disciplinary discursive self marginalization; 2) integrating gendered, socio-cultural understandings into art therapy practice; and 3) the importance of developing gendered, socio-cultural (feminist) understandings of self-starving women.

The final chapter of this dissertation is a postscript that develops a different gendered and socio-cultural understanding of the phenomenon of self starving women. Having finished the analysis of the construction of the concept of anorexia nervosa in the disciplines of art therapy and psychiatry, I found that there was a need for a gendered, socio-cultural explanation of self starvation among women. Ironically the psychiatric data pointed directly to this need but at the same time actively repressed and marginalized exactly this way of approaching this phenomenon. Accordingly, in my last chapter I decided to move beyond the analysis and description of the concept anorexia nervosa and its ramifications on women and attempted to provide a theory of self starving women. Building upon the phenomenological concept of female consciousness (Bartky, 1990), an extension of Foucauldian ideas of internalized societal control of the individual, a provisional theory of self starving women is developed and presented as a way of moving forward in the understanding and treatment of self starving women.

I have termed this last chapter as a postscript in the sense that it is beyond the core agenda of the dissertation which explores the construction of a concept (anorexia nervosa) in two disciplines (art therapy and psychiatry) and its ramifications on the construction of women. I included a gendered, socio-cultural theory of self starving women because I see this as an urgent ramification of my dissertation It is an important direction that needs to be taken in order to help these women who are suffering. Thus the postscript is a personal attempt to understand this phenomenon from the perspective of considering the discursive forces at play in constructing a consciousness in women that would lead to the phenomenon of self starvation and is designed to

start a process which should have a proactive influence on options for treatment of these women. In this direction my postscript develops a non-pathologizing and theoretical understanding of women who are diagnosed and defined as suffering from anorexia. It is a real attempt to describe the core behaviour of self starving women from within a theoretical perspective that is sensitive to gender and social-cultural context (both aspects that current psychiatric research has shown to be important). At the centre of this theory is the feminist idea that this self destructive behaviour is a response to symbolic aspects of the socio-cultural realm and that a theory of self starving women needs to explain what would make women behave in this way. More specifically this particular theory needs to explain how the common activity of women dieting turns into the life threatening activity of self starvation.

As a final comment in this first chapter, I would like to explain a terminological shift that appears between the postscript and the rest of the dissertation. Throughout the dissertation I discuss the term *anorexia nervosa* but in the last chapter I provide a theory of *self starving women*. The reason for this change in terminology in the last chapter is that the term anorexia nervosa is a medical term with a long disciplinary history. The first nine chapters of dissertation directly explore the way this term – anorexia nervosa – has been constructed in two disciplines over time and the ramifications of this on the wider construction of women. However, in actually explaining the phenomena of self starving women from a theoretical starting point which is different from that of the fields of medicine and psychiatry, using the term anorexia nervosa is inappropriate. Accordingly, in the postscript I have chosen to describe this phenomenon in the most basic descriptive terms. The phenomenon is that certain women starve themselves and as such the term self starving woman seems the most appropriate way to define them.

Chapter Two

The Power of Disciplinary Discourse: The Marginalization of Art Therapy Research

2.1 Situating My Discussion

Early in the process of conceptualizing this dissertation, I conducted an extensive literature search and I came across an article that dealt directly with an issue of central concern to me – a review of the role of art-based therapies in the treatment of eating disorders. At the time, when reading the article I had a negative gut response to the manuscript and felt insulted by, what I considered to be, the arrogance and ignorance of the writers. However, as will be seen in the extensive analysis that appears in this chapter, this article ultimately was useful and perhaps even pivotal to this dissertation in that it directly exemplified discursive, disciplinary power relations inherent to any discussion of the phenomena of self starving women termed anorexia nervosa within the medical literature. In other words, more than anything else this particular article brought directly into focus the disciplinary nature of knowledge construction dealing with eating disorders and the ways in which knowledge is validated or invalidated in discourse. The aim of this chapter is to provide an introduction to the theoretical assumptions relating to disciplinary discourse and power which inform the type of critical discourse analysis that I use in this dissertation and to exemplify these through the analysis of the case of the article written by Frisch, Franko and Herzog (2006).

2.2 'Disciplining' the Research and Therapy of Anorexia Nervosa

In 2006, an article entitled "Art Based Therapies in the Treatment of Eating Disorders" appeared in the journal *Eating Disorders* (Frisch, Franko and Herzog, 2006). According to Frisch, Franko and Herzog's (2006), the aim of their article is to "stimulate discussion regarding future research in art-based therapies and eating disorders treatment" (p.133). The authors feel that "Research exploring arts-based therapy that specifically investigates and addresses the unique characteristics of clients who have an eating disorder is warranted" (p.133) and they suggest that "a small series of randomized, controlled studies" (p.138) should be conducted. They also suggest that "short- and long-term follow-up data from basic outcomes studies" (p.138) be collected. In short they propose a very specific research program that would, in their opinion, provide valid

research information that could be used to evaluate the effectiveness of art therapy in treating eating disordered patients.

The first line of this article states the following: "Arts-based therapies are increasingly being employed, in conjunction with empirically valid traditional therapies, in the residential treatment of eating disorders" (Frisch, Franko and Herzog, 2006, p.131) This initial statement divides the potential therapies of eating disorders into two distinct groupings. In one group we have something termed by the authors "arts-based therapies" and the other group something that is termed "empirically valid traditional therapies." The implication is that the world of therapy for eating disorders is divided into those therapies that have empirical support (valid, traditional therapies) and those that do not have empirical support (arts-based therapies). In the continuation of this article the authors' state that: "specifically within the area of eating disorders, we were not able to find evidence of empirically valid studies conducted with this population" (Frisch, Franko & Herzog, 2006, p.132). In this article, three statements of this kind were found and this argument forms the central core of the manuscript supporting all of the recommendations made by the authors.

Beyond the fact that the statement that there are "no empirically valid" art therapy studies of eating disorders is inaccurate[1], the direct differentiation between art-based therapies and other therapy types is not a neutral, descriptive distinction; but rather a value judgment on the part of the authors on the potential contribution of art therapy to the field of eating disorders. The ramifications of this position by these authors is clear when they state: "It appears that the majority of residential eating disorder treatment programs support and employ at least one form of therapy that has not yet been shown to be an empirically valid primary, secondary or adjunctive treatment for eating disorders" (Frisch, Franko & Herzog, 2006, p.138). In other words, from the authors' perspective the role of art therapy is suspect and its contribution to the treatment of eating disorders unknown until a very specific form of knowledge construction (the "randomized, controlled study") is conducted.

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[1] The authors' position is predicated on a particularly restricted definition of the concept of empirical. Using their restricted definition of empirical a wide range of psychological and psychodynamic therapies (which are not arts-based) that are currently available do not have empirical support. At the same time, there are several studies of art therapy that do utilize systematic, empirical research methods (consider Rehavia-Hanauer, 2003 and Rabin, 2003)

Foucault (1980) in a discussion of the relationship of power and knowledge states that in cases such as the one discussed here we need to ask "What types of knowledge do you want to disqualify, in the very instant of your demand: 'Is it a science'?" (p.85). Pennycook (2001) in his discussion of the Foucauldian concept of power, rightly states that this question is a question concerning the politics of knowledge. The positioning, by the authors Frisch, Franko & Herzog (2006), of the randomized controlled study as the golden rule of knowledge construction is a political position that is used to marginalize and devalue in one broad sweep the collective knowledge of arts-based research and therapy concerning eating disorders. The authors, all working within a medical and psychological context, are using a disciplinary convention of value to judge research and definitions which find their source in a different epistemological orientation. This is an issue of controlling the borders of knowledge. For this medical/research team, the phenomenon of self starvation (termed within the medical discourse as anorexia nervosa) is a medical phenomenon and thus research concerning this issue must follow the guidelines of medical research. From the limited epistemologically and ideologically perspective of the authors of this paper any research that does not follow their constructed, disciplinary assumptions concerning the nature of knowledge construction is untrustworthy and hence marginalized.

In a response to a critique of their position these authors make their disciplinary position explicit. They state that:

> "Our use of the term "empirically valid" or "empirically validated" (also tagged as "empirically supported" or "evidence based") was not intended to be polemical. Rather, the aim was to make a particular distinction among available therapies. The following guidelines support our definition of empirically valid and our assertion that arts therapy has not yet been tested in this manner. The American Psychological Association's Division 12, Society of Clinical Psychology, requires empirically valid treatments to show superiority over some type of study control group or equality to an alternative treatment that has been shown in other studies to be beneficial. Empirical validation also is typically tested within the framework of treatment outcomes. Similarly, the National Health Service

> (NHS) National Institute for Health and Clinical Excellence (NICE) published a clinical guideline for the treatment of eating disorders that declares randomized controlled trials (RCTs) remain the most important method for establishing efficacy" (Frisch, Franko and Herzog, 2007, p.3)

It is not by chance that the authors resort to disciplinary intertextuality to support their value judgment. They refer directly to the policies of two powerful medical and psychological institutions: the American Psychological Association and the National Health Service. As argued by Pennycook (2001) in his discussion of critical discourse analysis, social reality is constructed through intertextuality and the study of these chains of texts reveals the nature of that social reality. Supposedly, the authors of this paper are merely messengers passing on the disciplinary judgment in accordance with the written rules of the field. In rhetorical terms, the authors see their position as uncontroversial since it is based on the textual pronouncements of powerful authorities and in compliance with the defined disciplinary guidelines for knowledge creation.

It is also interesting to note Frisch, Franko & Herzog's (2007) use of the word 'polemical' in the quote presented above. Through this word they are trying to create the impression that they are not involved in a passionate, persuasive argument (the meaning of the word polemical) but rather are merely stating a truth in relation to the definition of the words empirical, valid and research. The irony, of course, is that their desire to position themselves beyond the creation of an argument is the central aspect of their argument. As stated by Lazar (2005) in her discussion of feminist critical discourse analysis "the winning of consent and the perpetuation of the otherwise tenuous relation of dominance (Gramsci, 1971) are largely accomplished through discursive means, especially in the ways ideological assumptions are constantly re-enacted and circulated through discourse as commonsensical and natural. The taken-for-grantedness and normalcy of such knowledge is what mystifies or obscures the power differential and inequality at work" (p.7). For Frisch, Franko & Herzog (2007) the definition of valid research is self-evident and does not require any additional support. This sense of normalcy, taken-for-grantedness and deference to institutional, textual authority gives these authors the power to perform the textual act of disciplinary marginalization of collected knowledge textually enacted in their manuscript and at the same time to see this

act as non-polemical. This is a case of what the feminist, critical discourse analyst Lazar (2005) calls 'invisible power' that hides the enacted power relations in an illusion of normalcy and legitimacy. The denial of Frisch, Franko & Herzog (2006, 2007) of the presence of a passionate argument devaluing research and therapy relating to eating disorders conducted in the field of art therapy within their article does not remove the presence of this act of policing the boundaries of knowledge from their manuscript. What their denial does do is exemplify in very concrete terms the nature of disciplinary power enacted through accepted assumptions taken as givens beyond any requirement for justification or legitimization and without any realization on the part of the actors that these very assumptions (that justify all else) are socially constructed through discourse. Put simply, the value judgment enacted by these authors is not an act of self-evident, truth but rather an act of discourse which attempts to 'discipline' the field of art therapy both in the sense of a verbal admonishment and in the sense of demanding submission to the disciplinary requirements of the field of medicine.

2.3 Underpinning Assumptions and the Construction of Knowledge

In my brief, theoretical informed, analysis of Frisch, Franko and Herzog (2006, 2007), it is clear that two distinct sets of underpinning assumptions are present. This dissertation is written from a poststructuralist, feminist perspective and utilizes the research method of critical discourse analysis to investigate the disciplinary understandings of the phenomenon of self starving women termed within the medical-psychiatric literature as anorexia nervosa. This is a very different perspective than the one exemplified in the work of Frisch, Franko and Herzog (2006, 2007) who basically want to define anorexia and the effective treatment of anorexia through the single method of random controlled comparative trials. This emphasis on a particular method on both the part of Frisch, Franko and Herzog (2006, 2007) and myself in this dissertation is part of a larger philosophical orientation towards the issue of knowledge construction.

The argument put forward by Frisch, Franko and Herzog (2006, 2007) in their discursive act of devaluing and marginalizing research within the field of art therapy is, according to their own admission, not their own. As discussed above, in defending their position they draw on written explanations found in powerful institutions within the fields of medical and psychological research. The core argument can be summarized as follows:

valid knowledge construction requires the demonstration of cause and result relations of defined and manipulated variables compared to a control group. The method to achieve this is the experimental design within which specific variables are isolated and manipulated with outcomes statistically compared among the manipulations and a control group. When significant statistical difference among the manipulations and the control group are found, the causal relations investigated are considered to be valid knowledge.

Historically, this position can be traced to the philosophical orientation termed logical positivism and first proposed by the Vienna Circle in the first decades of the 20th century. According to Okasha (2002) in his introduction to the philosophy of science, the logical positivist approach to knowledge creation is characterized by its emphasis on the ahistorical process of scientific justification and its belief in an objective basis for distinguishing among different theoretical alternatives. As their name implies, logical positivists consider the justification of scientific knowledge to be a process that should be strictly controlled by logic. Central to the process of scientific justification is the concept that the evidence collected from the natural world can consist of neutral, objective, observable facts. From a logical positivist perspective, the question of which theory is correct is resolved through logical conclusion inferred from observable facts. In this framework, method takes on a particular importance in that the way to objective, valid knowledge is dependent on the researchers adhering to very specific guidelines in their experiments and research practices. As analysed by the critical, feminist psychologist Malson (1998) the logical positivist position "assumes an objective knowable reality" that is "grounded in experience and observation" (p.35).

It is this last aspect of logical positivism that creates the clearest boundary between the poststructuralist orientation that informs this study and the demands of Frisch, Franko and Herzog (2006). Succinctly defined the issue concerns the relationship between reality and discourse. The logical positivist assumption is that reality exists beyond the bounds of discourse. Discourse, especially in the linguistic sense of this term, reflects an externally valid reality. The two are distinct with discourse fulfilling the role of reflecting and documenting an autonomous, external reality. Accordingly, Frisch, Franko and Herzog (2007) explicitly object to the idea that they are involved in any form

of polemic (which would reveal that perhaps rather than objective, disinterested scientists they are in fact rhetoricians involved in the discursive construction of reality).

Poststructuralism, as a reaction to the totalizing generalizations of structuralism, objects to this dichotomy of reality and discourse. For poststructuralism, it is discourse that constructs reality and accordingly, discourse is seen as constitutive and not reflective. As stated by Malson (1998) poststructuralist theory "radically undermines the claims that scientific discourses objectively describe and explain a reality existing anterior to and independently of discourse. It recasts empirical 'facts' as theory- and language-dependent contentions (Lawson, 1985), and 'scientific methodology' not as a means to revealing reality but as a technique of constructing particular realities and truths" (p.38).

The ramifications of the difference between these two positions on what constitutes research are significant. If discourse constitutes reality and scientific methodology is a technique for constructing "particular realities and truths" then all we know about the nature of the world is suspect and all knowledge is politicized. Rather than viewing academic publications of research as objective individual investigations of the reality of anorexia nervosa, these same publications become part of a discursive entity that actively constructs the phenomenon of self starving women as a medical condition categorized under the heading of anorexia nervosa. Within this context, research into the nature of anorexia nervosa is a close consideration of the discourses within which anorexia is constructed. The concept of anorexia nervosa moves from a description of an external reality to an exploration of the ways in which this phenomenon is constructed in discourse. Malson (1998) whose work is seminal in this field summarizes her own poststructuralist, feminist discourse analysis of anorexia nervosa in the following terms:

> "This form of discourse analytic research is concerned, therefore, not with revealing any objectively knowable reality about 'anorexia' outside of discourse, but with analyzing discourses themselves as they are manifest in texts, talk, practice and institutions (see Henriques et al., 1984). It is concerned with elucidating the inseparability of discourses from their conditions of emergence and from the institutions and practices of which they are a part (see Walkerdine, 1984). It seeks to demonstrate how objects, practices, subjectivities and desires are constituted in and

> regulated by discourses and discursive practices and how the discursive productions of truths can be understood in terms of a 'micro-physics of power' (Foucault, 1979: 139) that operates upon the female body and upon the anorexic body" (p.44).

This dissertation follows a similar path to that of Malson (1998) in that it aims to explore the discursive disciplinary context within which the phenomenon of self starving women termed anorexia nervosa is constructed. As exemplified in the case of Frisch, Franko and Herzog (2006) discussed above, there are (among a wide range of additional discursive acts) different epistemological guidelines on how knowledge is constructed and disagreement over what counts as valid knowledge. There is also clearly a power relationship that is enacted through Frisch, Franko and Herzog's (2006) discursive act. They iterate demands on how knowledge should be constructed and at the same time marginalize existing knowledge within the field of art therapy. It is this aspect of the relationship between discourse and power that is explicated in the next section.

2.4 Power and Discourse

Foucault is the poststructuralist theorist most closely associated with the issues of discourse and power and accordingly it is to his theories that I will turn here. Consider the following statement made by Foucault (1972), in addressing the nature of medical discourse "Medical statements cannot come from anybody; their value, efficacy, even their therapeutic powers, and generally speaking their existence as medical statements cannot be disassociated from the statutorily defined person who has the right to make them" (p.51). He further states in the same discussion, that from the perspective of the historical analyst "We must also describe the institutional *sites* from which the doctor makes his discourse, and from which this discourse derives its legitimate source and point of application (its specific objects and instruments of verification)" (Foucault, 1972, p.51). As seen here, for Foucault the status of a statement that is made is not a factor of the internal linguistic characteristics of the statement; but rather, it is the statement's discursive embeddedness and relations with a wider range of discursive practices. These discursive practices situate both the statement and the speaker at the same time. In this sense a medical statement may be stated by a doctor but is made through the potential

that exists within the discourse to allow such statements that positions both the speaker and the statement made.

Most importantly for Foucault, discourse defines the identity of the speaker at the moment of speaking. Identity thus becomes a discursive entity shifting and changing through different discourses and discursive acts and not an essential internal aspect of the individual or a linguistic characteristic of the statements made. It is through discourse that identity is positioned. In this sense discourse and power are related for Foucault. The relationship is not one of an agent wielding power through discourse; it is that discourse is power. Malson (1998) summarizes this aspect of Foucauldian concept of discourse/power in the following way: "Discourses regulate and discipline by constituting fields of knowledge, instituting truths, constituting subjectivities in particular ways, positioning people within discourses and subjecting them to normalizing judgments (Foucault, 1977, 1979), so that power relations although unevenly distributed are everywhere (Foucault, 1978:95)" (p.29).

Frisch, Franko and Herzog's (2006) article exemplifies exactly this process. As analysed above their argument is based on the acceptance and promotion of a particular formulation of the concept of empirical research defined only as the experimental random controlled trial and drawn from both medical and psychological discourses. This definition defines the borders of the field of knowledge (what anorexia is and how it can be legitimately treated) and defines truth within this field of knowledge. By defining the field of knowledge in this way, the value of the authors work is enhanced and that of art therapists devalued. The usage of this normalizing judgment creates an uneven power structure in which the speakers position themselves above all art therapists through the usage of medical discourse. In this way they regulate what is known about anorexia nervosa and who can legitimately speak about this phenomenon.

It should also be noted that the current analysis of Frisch, Franko and Herzog's (2006) article (and this dissertation in general) presents another aspect of Foucault's concept of power. Discourse/power relations are not mono-directional. The enactment of power within discourse raises the option of resistance within discourse (Foucault, 1980). While Frisch, Franko and Herzog (2006, 2007) draw on medical and psychological discourses to construct a set of discursive positionings of art therapists, in this dissertation

I draw on a series of cultural analytical discourses to position Frisch, Franko and Herzog (2006, 2007). In this sense, my discursive act is only different from Frisch, Franko and Herzog (2006, 2007) in that I recognize the characteristics of my own discursive act (which, of course, is part of the reflective nature of cultural discourse). In discourse, power is enacted by a series of actors. Both Frisch, Franko and Herzog's (2006) manuscript and this analysis are examples of the meeting place and power struggles of disciplinary discourse interaction.

For Foucault (1980) "power is not something that is acquired, seized or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations" (p.94). Power is not beyond or before discourse and is not controlled by a single entity. Power is in discourse and through the enactments of discourse. As exemplified in the current analysis, discourses (and by extension fields of knowledge, truths, and the positioning of subjects) vie for their own positioning. Power is thus fluid in its discursive enactment and through a consideration of specific discourses one can view, what is termed by Foucault (1977), the "micro-physics of power" (p.139).

2.5 Discursive, Disciplinary Power

An important aspect of the current study is the organization of the analysis around the concept of discipline. This dissertation aims to explore the construction of explanations of the phenomenon of self starving women termed anorexia nervosa within specific disciplinary contexts. This position is consistent with the poststructuralist understanding that discourses constitute fields of knowledge, truths, subjectivities and position people in a series of power relationships. However the concept of a discipline as a central organizing component of this study needs some additional explication. Foucault (1972) in a lecture on the relationship of discourse and language specifies the following: "Disciplines constitute a system of control in the production of discourse, fixing its limits through the action of an identity taking the form of a permanent reactivation of rules" (p.224). Foucault (1972) further specifies that "disciplines are defined by groups of objects, methods, their corpus of propositions that are considered to be true, the interplay of rules and definitions, of techniques and tools: all these constitute a sort of anonymous system" (p.222).

The control a discipline has over discourse relates to the specific statements that can or cannot be made within the context of a specific discipline. According to Foucault (1972) for a proposition to belong to a discipline it must fulfil a series of conditions: it must refer to a "specific range of objects"; it must "utilize conceptual instruments and techniques of a well defined type"; it must "fit into a certain type of theoretical field" (p.223) and it must be made by a person who is "qualified to do so" (p.225). These conditions on acceptable disciplinary statements creates a boundary for the type of statement (and hence knowledge) that is within the disciplinary realm. This boundary creates a situation in which only a subset statements that have been the discussion of a particular phenomenon (or object) will be included within the discipline as true and worthy statements. As stated by Foucault (1972) "Within its own limits, every discipline recognizes true and false propositions" (p.223). Accordingly the set of actual statements made concerning a particular phenomenon is larger than those that any given discipline accepts. Those statements that fulfil the conditions of the discipline are recognized and considered true. This creates a hierarchy of value within the sets of statements that are made around particular phenomena with some statements valued and used and others devalued and discarded. A power relation in this sense addresses the ability of a statement to be accepted and repeated within the discourse. Control of the discourse around a specific phenomenon by the discipline, thus results in control over the way the specific phenomenon is understood, constituted, and discussed. The power of disciplinary discourse is the power to construct understanding.

In this sense Frisch, Franko and Herzog's (2006) paper is a case of discursive, disciplinary power. The argument within their paper reflects (and is directly drawn from specific written textual statements) the discourse of their discipline. Their suggestions concerning the type of research required so as to construct acceptable knowledge reflect their disciplinary practices and theories of knowledge construction. The basis upon which they enter into this evaluation of art therapy results from the object under consideration – the treatment of a mental disorder that their own discipline has already constructed as an object within the discipline. What their disciplinary position allows them to do is to further enhance the hierarchy of value that is to be assigned to the statements coming out of the field of art therapy in relation to the phenomenon of self starving women. Their

argument is an issue of regulating the variety of statements that potentially could be made in relation to anorexia nervosa and to ensure that these statements uphold the disciplinary practices of medical psychology.

2.6 Chapter Summary

The outcome of the analysis presented in this chapter is an understanding of the role that disciplinary discourse can have on the construction of objects and phenomenon through its ability to recognize and accept certain statements and to devalue and discard others. Specifically, the components of the discipline – its objects, methods, corpus of true propositions, rules, definitions, techniques, tools and practices – construct a system that generates and legitimizes acceptable statements. Any given statement only has (or has not) value through its relationship to the wider context of disciplinary statements and practices. Accordingly, as in this dissertation an analysis of the constitutive aspects of a disciplinary discourse allows an understanding of the statements themselves and their relationship to the discipline within which they were constructed. A comparison of two disciplines describing the same object but from different disciplinary positions should make it possible to situate statements and explore on a wider basis the disciplinary aspect of knowledge construction. In relation to the phenomenon of self starving women my aim is parallel to that of the feminist critical psychologist Helen Malson (1998) when she states that by exploring "the ways in which discourses constitute and regulate knowledges, objects, practices, subjectivities and experiences... ... elucidating the socio-historical specificities of these power/knowledges" it should be possible "to reconceptualize 'anorexia' and 'the (anorectic) woman' in terms of multiply produced discursive constructions" (p.42) and thus offer new insights into the way we understand how these women are being constructed in discourse.

Chapter Three

Feminist Critical Discourse Analysis of Written Text and Visual Representation

3.1 Situating the Discussion of Feminist Critical Discourse Analysis

In the last chapter, the concepts of discourse, discipline and power were discussed and exemplified in a specific case of the marginalization of art therapy knowledge relating to anorexia nervosa. Based on Foucault's (1972) concept and definition of a discipline the last chapter developed the idea that disciplinary power manifest itself through the control of statements that are validated and invalidated in order to allow certain constructions of meaning to exist and be propagated and others to be marginalized and discounted. This description of disciplinary power gives prominence to written texts in the sense that it is easiest to follow the nature and status of a statement by considering its written textual presence. The history and intertextuality of these written texts provides documentation of the nature of accepted knowledge within a discipline. In this dissertation the construction of the concept of anorexia nervosa is explored through a critical feminist discourse analysis of published academic articles and books that deal with anorexia nervosa in the disciplines of art therapy and psychiatry. The aim of this chapter is to present my understanding of the concepts of discourse, text, image and critical discourse analysis and to develop my position on the central theoretical propositions that underpin the methodology of this dissertation – feminist, critical discourse analysis of written text and visual representation.

3.2 Critical Discourse Analysis

Critical discourse analysis (CDA) is a form of linguistic analysis that is predicated on the concept that language is a form of social practice in which text is situated within a specific historical and social context (Fairclough & Wodak, 1997; Janks, 1997; Wodak & Meyer, 2001). The social understanding of language, discourse and communication is a crucial starting point for a discussion of CDA. Fairclough (1989, 1995) a major figure within CDA, specifies that there are three interrelated levels or dimensions to any discourse. These three levels consist of the textual object, the processes of text production and reception and the socio-historical context that direct the process of production and reception (Janks, 1997). This three part construct situates language within a social context that directs the ways in which the textual object is formed and the ways in which it is

understood. This position stands in opposition to assumptions that texts and language function in some autonomous, decontextualized way. As an initial position CDA, situates all language texts within a social context that directly influences the semiotic value of the text.

The linguistic roots of CDA explain, perhaps, the special emphasis CDA places upon the role of language in the construction of social relations. Language plays a special role here in that it is through language that meaning is constructed and it is through meaning that social relations are controlled. This position echoes Thompson (1991) contention that ideology as a set of specific symbolic meanings is the way in which societies maintain relations of dominance. For Thompson (1991) domination in society is maintained by the construction and control of a particular set of symbolic meanings. Accordingly, the control of social relations is really an issue of controlling meaning and language is a prime resource for exactly this means of social control. Language through its meaning construction processes creates symbolic domination.

Although not usually referenced within the CDA literature, to further explore the idea of the symbolic domination in society which is central to the CDA research agenda it is worth briefly discussing Bourdieu's (1991, 1997) concept of habitus. Habitus structures the relationship between the individual and social structure. Habitus is a socially acquired deep classification system that generates an individual's ways of being in the world. In this sense habitus is a set of generative dispositions that direct individuals to think, act and believe in socially informed ways. Habitus is a form of socially constructed subjectivity and reflects the formative experiences from ones environment. In Thompson's (1991) terms, habitus is the internalization of symbolic meanings (ideology) that then become the source of social control maintaining the status quo of relations of dominance. Wodak (2001) a central CDA researcher, states that a central aspect of CDA research is the "the attempt to understand the formation of the individual human being as a social individual in response to available 'representational resources'" (p.6).

Against this backdrop of symbolic control, CDA extends linguistic analyses of texts to offer an understanding of the ways in which social structure and language are related. In this sense CDA is an approach that places the relationship between language and power at the heart of its research agenda. Wodak (2001) defines CDA as

"fundamentally concerned with analysing opaque as well as structural relationships of dominance, discrimination, power, and control manifest in language. In other words, CDA aims to investigate critically social inequality as it is expressed, signalled, constituted, legitimized and so on by language use" (p.2). In this formulation of CDA, Wodak (2001) points out the role of a linguistic analysis in uncovering the ways in which language enacts its symbolic control over the individual and manifests and recreates relations of domination and discrimination in society. It is the careful, critical analysis of the discourse (and its propagation of a series of specific symbolic meanings) that allows these social relations to be exposed and made explicit.

A particular aspect of habitus is the naturalness of its social classificatory dispositions. In many cases, the symbolic meanings which uphold specific social relations of dominance and discrimination are sensed by the individuals and societies that are involved as natural and given. These symbolic constructions can be experienced as a fixed, given reality that is in no way ideological. In other words, the construction of society with its inherent relations of power among various social groups is often hidden and obscured through the naturalness of the symbolic categories that are used to uphold this structure. CDA, as method of research and as a form of social activism, offers a way of approaching the symbolic construction of social relations and making explicit the hidden aspects of social control and discrimination.

The critical aspect of CDA is a commitment to "emancipation and enlightenment" (Wodak, 2001, p.10). Through its analyses CDA aims to make individuals aware of the ways in which their understandings and beliefs are constructed. This critical approach provides the individual with insight into the ways in which their thinking and beliefs have been moulded. Of special importance to CDA is the analysis of the ways in which language is used to discriminate and marginalize various groups of individuals within society. The linguistic construction of minority groups and women and the associated social discrimination has been one of the focuses of CDA. There is an assumption that since social relations are predicated upon the presence of symbolic meanings which uphold certain social constructs that through the close analysis of the discourse the equalling of power relations within society will follow. In other words, the actual analysis of the discourse and the associated insights into how meaning is formed in this discourse

is both an act of enlightenment and emancipation which should lead to a more equitable society.

3.3 Widening the Definition of Discourse

As described in the previous section, CDA is a form of linguistic analysis that addresses the way language is used to obscure (and hence reinforce and reconstitute) existing power relations within social systems. The aim of CDA is to expose the nature of these power relations and the ways in which language creates them and thus offers emancipation through enlightenment. Pennycook (2001) in his discussion of critical applied linguistics, points out that the enlightenment stance taken by CDA suggests that there is a form of discourse which is transparent and free of power relations. In other words, there is an assumption here that CDA through its linguistic analysis produces an alternative discourse of truth. As argued by Pennycook (2001) this position involves a certain degree of inconsistency on the part of CDA practitioners and results from the empirical linguistic tradition within which CDA is constituted. Particularly problematic is the assumption that there is a scientific discourse that provides transparent truth beyond power relations. As seen in the last chapter, movements towards a scientific basis and criteria suggesting ideal discursive constructs are in fact nothing more than disciplinary constructs and often marginalizing in themselves to other ways of understanding the world.

The methods of CDA do not produce an alternative truth but rather they provide insights into the way power works within discourse and are part of a practice of resistance enacted through discourse. As analysed by Pennycook (2001) the issue here addresses the definition of discourse. CDA defines discourse as a linguistic entity that can be differentiated from ideology. As constructed within CDA discourse and ideology are presented as two separate entities in which language is directed by the external ideology of dominant forces. Language manifests an external ideological position and language is manipulated in order for certain powerful groups to maintain their power within social systems. In particular, language is seen as a force that obscures and hides power relations. The position taken in this dissertation is closer to Foucault's understandings of discourse as intertwined with power. As discussed in the previous chapter, discourse is not divorced from power but rather discourse constitutes power through its ability to generate and

validate a specific set of meanings. In this sense power is intrinsically situated in discursive practice and discourse is a site of contestation and resistance as well as dominance and marginalization.

3.3.1 The Material Components of Discourse

There is another important distinction that needs to be made here. CDA has tended to overemphasize the role of language in the constitution of social relations. Foucault has a much wider sense of what constitutes discourse. As argued by Malson (1998) for Foucault discourse is not language that reflects external social relations but rather a system of social practices that constitutes its own objects of observation. Disciplinary discourse generates knowledge that includes conceptual as well as material components. For example, in Foucault's (1987) analysis of mental asylums the material practices and objects described are constituted within the generative framework of what is possible within the definitions of medical-psychiatric discourse. Thus, for Foucault discourse is not limited to language. Similarly in the discussion of anorexia nervosa the material body plays a significant role within the medical-psychiatric discourse that includes a range of material practices around the body.

3.3.2 Discourse and Intertextual Relations

There is another aspect of discourse that needs to be addressed. From the perspective of Foucault (1972), discourses are dispersed and any consideration of the construction of meaning requires the consideration of intertextual relations. The construction of knowledge and hence the regulation and generation of specific statements considered to be of value does not happen within a single site but rather is dispersed among different discursive entities. The exploration of discourses involves the explorations of relations within a set of statements that have been made and a close consideration of how the system of statements functions to promote and generate a specific set of statements as opposed to a different set of potential statements. This borrowing and promotion of various statements and repression of others happens in an intertextual context which has historical aspects.

3.3.3 Discourse and Mulitmodality

The current study, which deals with the construction of anorexia nervosa within the discipline of art therapy, sees a significant role for signification systems in addition to

language. In particular, as this study explores art therapy, the role of visual representation will be addressed. From a theoretical perspective the current dissertation has a multimodal CDA approach and explores the relations that are created among the visual and linguistic modalities of representation. This position should be seen as enhancing existing moves within CDA that address visual semiotics. Researchers such as Kress and van Leeuwen (1996) have looked at the ways in which visual representations create meaning within a CDA perspective. As argued by Lazar (2005) and Hogan (1997) for feminist concerns over the way gender is represented, a multimodal analysis of discourse provides important avenues for insight.

3.4 Feminist Critical Discourse Analysis

As discussed in the previous section, the concept of discourse used in this dissertation draws upon Foucault's specific post-structuralist development of this term. Foucault (1978) offers a detailed analysis of the discourses that generate sex and sexuality and how the body is a discursive site of struggle. However, Foucault has been critiqued for not exploring the role gender plays in positioning and regulating subjectivities in discourse (Malson, 1998; McNay, 1992). A central aspect of the current study is the importance placed on a feminist perspective in addressing the discursive, disciplinary construction of anorexia nervosa. In this sense this study follows Malson's (1998) position that feminist, post-structuralist research on anorexia should involve "an exploration of the discourses in which anorexia, femininity, subjectivity and the body are discursively constituted and regulated" and "the ways in which the micro-physics of power that functions in discourse operates upon the female and the anorexic body" (p.44).

This manifestation of a feminist critical discourse analysis within a post-structuralist orientation requires some clarification and explanation. Feminist research is based on the critical assumption that gender is an ideological category that informs and regulates social relations and structures. Lazar (2005) summarizes this position when she states that "gender is understood as an ideological structure that divides people into two classes, men and women, based on a hierarchical relation of domination and subordination, respectively" (p.7). In this sense, a feminist approach to discourse analysis has a predisposition to the exploration of gender based hierarchical domination of

women. As directly stated by Lazar (2005) as "feminist critical discourse analysts, our central concern is with critiquing discourses which sustain a patriarchal social order: that is, relations of power that systematically privilege men as a social group and disadvantage, exclude and disempower women as a social group" (p.5). Borrowing a post-structuralist formulation, feminist CDA views discourse as a site of struggle in which resistance and contestation can be enacted. In this formulation feminist CDA becomes the critical analytical means to exposing and resisting discriminatory gender constructions. However, it should be noted that post-structuralist thought objects to both the prioritizing and essentializing of women's experience and to the concept of the product of the feminist analysis as a discourse of truth. Malson (1998) contending with a similar complexity offers the following formulation "Feminist post-structuralist research is therefore concerned not with an exploration or reclamation of an authentic female experience but with analysing ways in which women's subjectivities, experiences and desires are discursively constituted and regulated" (p.39).

Based on a post-structuralist concept of power and discourse as intertwined, feminist critical discourse analysis utilizes the collected methods of CDA approaches to explore the ways in which gender, power and ideology work in specific discursive settings. Feminist research has long recognized that gender poses a particular problem for analysis in that gender constructions are so deeply rooted within specific discourses that they do not appear to be constructions of domination at all (Lazar, 2005). In addition, in the early 21st century in which there are assumptions that feminism is unnecessary in a post-equality world where women's rights have supposedly been achieved, the discursive structures of gender control have become more subtle and to a certain extent hidden even deeper (Lazar, 2005). It is against this context of obscured discursive control that feminist CDA aims to explicate and explore the ways in which gender is formulated and the subjectivities that it generates.

Feminist critical discourse analysis involves a range of different micro and macro levelled analyses in order to achieve its aims. While it would be inappropriate at this point to explicate all the divergences in feminist research practice, it is important to note the convergence of these approaches around a set of shared questions and understandings. A central aspect of feminist research within the CDA context is the idea that gender

usage in discourse has a cognitive function. Gender, often positioned as a core underpinning distinction among people, has a significant interpretive function in discourse. As an interpretive category gender is used to make sense of the world without deep consideration of the specific discursive construction involved in the usage of this interpretive category. This creates fertile generative ground for conceptual and material discrimination based on often assumed 'natural' characteristics assigned to specific gender definitions.

Underpinning this interpretive role of gender is the discursive specification of a series of gender representations, gender relations, gender roles and gender identities that are internalized by participants in the discursive setting. These internalized cognitive gender definitions are both constituted by and reproduced in discourse and direct every aspect of life. In this sense, a woman's experiences are part of and directed by the underpinning discursive constructions of gender. Early feminist research dealt directly with the idea of naively expressing the experiences of being a woman within the social context of a patriarchal society. As stated above, feminist post-structuralist approaches have a more sophisticated understanding of these experiences and see them as constituted within a discursive frame. What is of interest is the way in which discourse constructs these experiences and processes of contestation in relation to the meanings that evolve.

For the purposes of this dissertation and based on the summary above, a multilevel scheme for feminist CDA as a research method can be proposed. A feminist CDA approach involves the following levels of analysis:

1. *Gender as Interpretive Category*: The first level of analysis considers the role of gender in interpreting woman in the world and explores the way in which gender is used to explain specific phenomenon.
2. *Gender Definitions of Relations, Roles and Identities:* The second level of analysis explores the specific and explicit definitions assigned to women that are used to explicate and explain phenomena in the world
3. *Gendered Experiences:* The third level of analysis addresses the world experiences expressed within discourse by women in different situations.

4. *Gender Representations:* The fourth level of analysis explores the types of representation of women that are presented within discourse to exemplify women's relations, roles and identities.

These four levels of analysis are not considered to be discrete but rather as mutually informative and it is further assumed that all these levels contribute to the discursive construction of gender. In addition and in accordance with post-structuralist thought it is assumed that in any given discourse the specific construction of women may be contested and multifaceted. One of the main avenues for exploration consists of looking at the ways in which different definitions and representations are promoted and repressed at different points in discourse. This should allow the exploration of power and resistance and to explicate the way a specific discourse functions to generate and restrain specific understandings of women which in turn allow the reaffirmation and maintenance of unjust social relations. As discussed in the previous chapter in relation to Foucault understanding of disciplinary discourse, as an analytical tool the investigation of repressed and preferred statements concerning gender is a central methodology for exploring the way a specific discourse constructs gender.

3.5 Feminist Analysis of Visual Representation

As discussed in the previous section, gender representations are part of the discursive framework that defines women. One disciplinary context within which the visual aspects of gender description have been theorized is the field of feminist art therapy. Hogan (1997) a leading feminist art therapist positions her research agenda in the following way "I shall examine contemporary representations of women. Representations include images which in this analysis are not seen as 'mirrors' which simply reflect reality; rather, representations in this usage are conventions and codes which express those practices and forms which condition our experience and therefore in part constitute our reality" (p.21). In this formulation images of women are part of a wider discourse that constructs gender and as such creates women's experience. This constitutive aspect of images is a discursive tool for constructing gendered social relations. As stated by Hogan (1997) the "construction of gender differences sets up different pressures and constraints for women and men. Normative roles are in various ways oppressive and can become for both sexes the source of conflict and anxiety"

(p.21). As pointed out by Hogan (1997) these gender differences "are embodied and sustained in the images and texts that surround us in our daily lives" (p.21) and as such are consistent, constitutive and often not explicitly recognized as hegemonic, ideological constructions. These everyday images with their inherent gender definitions "position and limit the individual and have a vital role in determining subjective reality" (Hogan, 1997:21).

Within the feminist art therapy literature, the images of women are deeply embedded within a series of discursive contexts (Hogan, 1997). In accordance with both post-structuralist understandings and art therapy approaches, images are not considered to have inherent, self constituted meanings but rather are part of a much wider semiotic structure. Hogan (1997) in a discussion of the meaning of images of mother and child states that the "meaning of the representation is generated by the reader of the image, the depiction itself and the intertextual space of all other images of mothers and child" (p.29). The image takes on meaning through the reader's discursive negotiation of a specific image within an intertextual space. The specific depiction (of gender) is discursively situated. Potentially, in relation to any visual depiction a multitude of alternative meanings can be assigned; however the discursive nature of meaning construction creates a situation within which a specific set of interpretations will be preferred and other options repressed. In relation to Foucault's position on disciplinary discourse and in relation to art therapy, this principle of the preference for specific interpretations and the repression of others will be present within the art therapist's understanding of specific visual representation produced within the art therapy process. This is an important principle for the analysis of disciplinary understanding that manifests itself as a consideration of the specific interpretation that is assigned within discourse to an image and a consideration of other options that have been repressed by the same discourse.

Hogan (1995, 1997) has indeed explored from a feminist perspective disciplinary uses of images and reached a series of important methodological and substantive conclusions concerning how images are used and how woman have been constructed. Hogan (1995, 1997) has focused on the use of images in medical and psychological discourses. From a methodological perspective her work directs careful consideration towards the particular representation and then considers the specific relations, roles and

identities that are inherent in this depiction and the ways in which this functions as a core interpretive concept for explaining phenomena in the world and supporting discriminatory social relations. Substantively, Hogan (1995, 1997) has continued work by other feminist researchers (such as Showalter, 1985) who have addressed the ways in which medical, psychiatric discourse situates women and fulfils the role of positioning women in a subordinate social role. Covering a range of different specific phenomena Hogan (1995) succinctly states that women have been "represented historically as threatening the moral order and social stability of society. We were (and still are) portrayed as dangerous and dishonest (like children) and more controlled by our biology than men" (p.21). These general propositions concerning women were translated into a series of very specific assertions about female conditions, medical and psychology treatment and woman's roles in society and analysed by Hogan in relation to a series of images of women historically used in medical discourse. In addition, as noted by Hogan (1997) a wide range of explicit medical and biological justifications within medical, psychiatric discourse was directed at constructing and supporting exactly these positions. It is important to note that as argued by Hogan (1995, 1997) visual images played a significant role in medical discourse and were used to situate women in very particular ways.

Hogan's (1995, 1997) research raises an issue that is of importance to the feminist art therapy approach of this dissertation – the associated processes of medicalization and pathologization of women's condition. Medicalization, is inherently a discursive process in which a medical vocabulary is used in order to define a problem (Bell, 1987). The use of a medical vocabulary transforms human experience which differs from expected (socially and discursive defined) normative behaviours into a medical disorder. As such, medicalization, as the definition of a behaviour or condition in medical terms, facilitates pathologization. As pointed out by Chesler (1972) and referenced by Maracek & Hare-Mustin (1991) some feminist work has seen the medicalization of women's behaviour as a tool for "discrediting and punishing women who do not conform to man's interests" (p. 524).

Maracek & Hare-Mustin (1991), Showalter (1985) and Ussher (1995) offer extensive evidence of a history within the medical profession of transforming conditions

and behaviours associated with women into problematic medical conditions. In their historical review, Maracek & Hare-Mustin (1991) reveal a range of medicalization practises from 19th century cures such as the usage of "clitoridectomy as a cure for masturbation" (p. 522) to psychoanalytic ideas which defined women as suffering from "penis envy" and pathologized early mothering. In the 19th century women were diagnosed with hysteria, neurasthenia, nervous disorders such as anorexia hysteric and anorexia nervosa all of which prevented women from gaining access to "male" professions, higher education and political rights (Showalter 1985). Importantly for this dissertation, in the late 20th century (and into the 21st century) the processes of medicalization and pathologization are directly tied to the workings of medical diagnosis. It is diagnosis that transforms someone into a patient with a medical condition through the process of labelling of experienced phenomena with medical terminology. From a feminist discourse perspective, the process of the medicalization of women's conditions leads to a situation in which aspects of legitimate responses to oppressive societal and discursive forces are ignored while at the same time these responses can be defined as a medical condition requiring pharmaceutical and therapeutic intervention.

The current dissertation continues work conducted by Hogan (1995, 1997) on the ways in which gender is defined within art therapy and medical, psychiatric and psychology discourse. Hogan (1997) defines this part of her feminist art therapy research agenda as the exploration of the "culturally constructed nature of psychiatric illness and how this is linked to gender'' through an analysis of "representations of women dominant in nineteenth century medical discourses" (p.14). This dissertation in relation to published research in art therapy and psychiatry considers the way these disciplines construct the psychiatric concept of anorexia nervosa and the ramifications of this discursive construction on the representation of women. Specifically in relation to art therapy, this dissertation considers the ways in which visual images are discursively used to construct anorexia and gender.

The integration of Foucault's position on disciplinary discourse and Hogan's (1997) theoretical positioning of the image offer a powerful critical tool for the analysis of visual representations for this dissertation. The principle described here would suggest that from an analytical perspective the visual representation is open to various

understandings from the view point of the therapist, patient and external viewer of the visual representation but within the published article itself the art therapist researcher has chosen to say specific things about this visual representation and by extension about her understanding of anorexia nervosa (and women). A careful consideration of which specific interpretation is expressed by the art therapist researcher as a choice among various different potential options and what specific options have been repressed by this choice allows a consideration of the generative aspects of the disciplinary discourse of art therapy.

3.6 A Summary of Feminist Critical Discourse Positions

Reflectivity and explicitness are central concerns of research conducted within the framework of post-structuralist theory. The aim of the second and third chapter of this dissertation was to discuss the central understandings and theoretical positions that inform this study. Before explicating the stages of research and the methodology of this dissertation, this section offers a succinct summary of the theoretical positions that underpin the methodology used in this dissertation. The methodology of this dissertation is based on the following theoretical propositions:

1. All knowledge is socially and discursively constructed
2. Discourse embodies and constitutes social relations
3. Discourse is multimodal and includes textual, visual and physical entities.
4. Disciplinary power is discursive and consists of the power to promote, regulate and repress certain meaning statements
5. The system of statements that constitute disciplinary knowledge is contested and at any given moment in a range of discourses a series of alternative statements are made (and repressed).
6. Disciplinary discourse is dispersed across a range of intertextual relations which promote a certain set of specific statements that are used to construct a specific set of objects, conceptual instruments and identities.
7. Disciplinary discourses contest statements made concerning specific phenomena of interest to the discipline
8. Critical discourse analysis investigates the ways in which specific discourses construct specific sets of social relations and identities.

9. Feminist critical discourse analysis investigates the ways gender is discursively used to construct unjust social relations.

Chapter Four

Research Methodology

4.1 Reflectivity in Research

The aim of this chapter is to provide a systematic description of the methodological aspects of this dissertation. A characteristic of poststructuralist research practices is the importance of reflectivity and transparency in research activity (Alvesson & Skoldberg, 2000). Since research is always situated, a discussion of the researcher's considerations and actions in conducting a presented investigation allows a much clearer understanding of the epistemological aspect of the study to emerge. In this light, the current chapter explicitly describes the ways in which the research reported in this dissertation was conducted and explains the reasons for the various decisions made.

4.2 Research Questions

As outlined in the first chapter, this dissertation aims to explore the disciplinary understandings of anorexia nervosa and the associated construction of women within the disciplines of art therapy and psychiatry. The study addresses disciplinary texts and is organized around the following specific research questions.

1. How is the phenomenon of self-starving women (termed anorexia nervosa) explained by prominent researchers within the disciplines of art therapy and psychiatry?
2. In what ways does the discourse inform and constrain the production of disciplinary explanations of the phenomenon of self starving women (termed anorexia nervosa) within the fields of art therapy and psychiatry?
3. In what ways are women constructed and represented within the predominant explanations of the phenomenon of self starving women (termed anorexia nervosa) within the disciplines of art therapy and psychiatry?
4. What are the implications for art therapy practice? How might art therapists modify their work in the light of the findings?

4.3 Research Design

This research project is informed by feminist critical discourse analysis approaches to research and builds upon the discussions presented in Chapter Two and Three of this dissertation. I use the word "informed" purposefully here in that each critical discourse analysis project, especially within a poststructuralist feminist frame

involves making very specific and contextual decisions. The contextual nature of all discourse analysis and the presence of different types of discourse analysis add to the need for a discussion of the research decisions made for this dissertation. Thus the aim of this whole chapter is to provide insight into how the studies presented in this dissertation were conducted and to explain why specific decisions were made.

There are five core principles which direct the particular methodology used in this dissertation: 1) the organization of analysis according to disciplines; 2) the usage of quality, published academic materials within disciplinary contexts; 3) the analysis of disciplinary guidelines in their historical context which inform the construction of concepts within the discipline; 4) the analysis of the concept of anorexia nervosa with disciplinary contexts; and 5) the analysis of the ways in which the construction of women informs and is informed by the definition of the concept of anorexia nervosa within specific disciplines. Together these principles direct a very particular process of organizing data, collecting data, and analyzing data which is explicated below.

4.3.1 Disciplinary Organization

The decision to organize the analysis according to disciplinary contexts has serious ramifications on the way this study was conducted and how it is presented in this dissertation. Basically, this dissertation addresses two different disciplines - art therapy and psychiatry - and these disciplines are very different in their orientations. The principle of disciplinary organization in these circumstances dictates the necessity for conducting and presenting two different studies. As will be seen in the coming chapters, there were aspects of the study of art therapy that were different from the study of psychiatry. But these differences, explicated below, result from the decisions to look at knowledge construction within the framework of specific disciplines. Accordingly, the design, analysis and presentation of the data was influenced by a close consideration of what we know about each of these disciplines and how they function in constructing knowledge and resulted in the development of two distinct but interrelated studies.

4.3.2 Academic Materials: Disciplinary Corpus Construction

The second principle directs a very specific choice of materials to analyze. Broadly, the principle is that quality, published academic materials will be used as the core data in analyzing the construction of anorexia nervosa and women within each of

these disciplines. This broad decision is grounded within the idea that professional publication within accepted and valued academic outlets such as peer reviewed journals and academic book presses is the way in which disciplines formalize and announce their research findings. Academic publication is the site at which knowledge is presented and disseminated. Accordingly, the decision to analyze this body of materials is justified as this type of data is recognized as an accepted way to produce knowledge.

The actual operationalization of this core principle into a methodology is not as straight forward as it might seem at first and furthermore is dependent on the nature of the discipline being addressed. In other words, the principle of choosing academic materials to analyze and the decisions to organize this dissertation according to specific disciplines meant that different decisions were made for corpus collection in art therapy and psychiatry. Two factors specific to each of these disciplines really dictated the final decisions made. The first factor related to the amount of academic materials published by each of these fields. In the field of psychiatry, there are thousands of articles on anorexia nervosa; in the field of art therapy there are only a relatively limited number of articles that have been written. Accordingly, in art therapy it is possible to address the complete corpus of materials; whereas in psychiatry this is impossible. The second factor is the presence (or absence) of existing research dealing with the description of the history of the concept of anorexia nervosa. Previous research has been conducted in relation to the discipline of psychiatry concerning the genealogy of the concept anorexia nervosa (Malson, 1998) but no similar study has been done in relation to the discipline of art therapy. Thus, a decision was made to address the whole corpus of academic art therapy materials dealing with anorexia nervosa and to address only a limited subset of materials in psychiatry.

A series of subsequent decisions specific to the study in each discipline needed to be made. In relation to the field of art therapy a decision was made to address all published articles which met a series of basic criteria. The criteria were drawn from an analysis of the importance of visual representation to the field of art therapy and were as follows:

1. The explicit designation that the author of the publication is an art therapist working with female anorectic patients.

2. The usage, interpretation and presentation of visual representations within the published manuscript.
3. Articles, book chapters and books within peer reviewed academic journals and publishing houses.
4. Academic materials that are referenced within the disciplinary literature as a source for understanding and treating anorexia nervosa.

The criteria were designed to help identify published academic research within the field of art therapy that would be useful for the purposes of this dissertation. Based on these criteria an extensive digital and library search was conducted that produced a corpus of 17 articles, books and book chapters that were used in this analysis.

For the discipline of psychiatry the decision on a corpus for the analysis of the construction of anorexia involved two different stages. As stated above, it was very helpful that Malson (1998) had conducted a poststructuralist study of the construction of anorexia during the 20th century and provided a taxonomy of explanations of anorexia nervosa. Furthermore, it was helpful that the discipline of psychiatry has journals dedicated to the issue of eating disorders. The first stage of corpus construction involved validating and evaluating understandings of anorexia nervosa in the period between the end of Malson's (1998) analysis and the beginning of the 21st century. In other words, whether the explanatory categories found by Malson (1998) were still valid in 2009. In order to conduct this analysis, a decision was made to analyze all the articles published in three major psychiatric eating disorders journals during the year 2009. This consisted of 101 journal articles in three major journals – the *International Journal of Eating Disorders*, the *European Eating Disorders Review* and *Eating Disorders*. This was the initial corpus for analysis.

The second stage of collection of materials for analysis in the field of psychiatry consisted of current discussions and reviews of the DSM IV and proposals for the revision of the DSM V. An analysis of the power structure of the field of psychiatry in relation to other fields of mental health revealed a central role for the DSM as a tool that really controlled and directed the field of mental health. Accordingly, an analysis of the reviews and proposals for this important document over the definition of anorexia nervosa was felt to be a way of exploring current trends and understandings within the

field of psychiatry concerning anorexia nervosa. Thus, this body of reviews and proposals was the second corpus that was analysed.

4.3.3 Disciplinary Guidelines and Historical Context

In both the discipline of art therapy and psychiatry historical analyses have been conducted to explore the guiding principles of each field. Accordingly a starting point for the discursive analysis of the construction of the concept anorexia nervosa in each discipline consisted of a consideration of the nature, history and characteristics of each field. The aim in each case was to try and understand the issues that were of importance in each of these and how these directed the process of knowledge construction. This aim was mainly achieved through the reading and discussion of secondary materials that describe aspects of each of these fields.

4.3.4 Analyzing the Construction of Anorexia Nervosa

The analysis of the construction of anorexia nervosa within the collected corpuses for art therapy and psychiatry is the central task of this dissertation. As already pointed out in the above sections, the chosen corpus of materials was different for the two fields. In addition, the way each of these corpuses was addressed was different. I will start with the discipline of art therapy. Since there was no previous history of poststructuralist or discursive historical work on the construction of anorexia nervosa in the field of art therapy, a decision was made to conduct a detailed analysis of each of the articles and art therapy researchers who had addressed anorexia nervosa. In other words, an analysis of every individual article, book and book chapter was conducted and presented in Chapter Seven. After dealing with each individual art therapy researcher, in Chapter Eight an analysis of the historical development was conducted so as to present a range of ways in which anorexia nervosa had been addressed within the academic, art therapy literature.

The actual process of analysis in the discipline of art therapy was directed by a close consideration of three specific points of focus: 1) A consideration of the *explicit, written interpretive statements* used to describe and explain the concept of anorexia nervosa and the phenomenon of self starving women; 2) An analysis of the *intertextual chain of reference* through which specific interpretative statements appearing in the explanation of anorexia nervosa are supported and promoted; and 3) An analysis of the

visual representations presented by art therapy researchers in their explanation of anorexia nervosa.

As a process of analysis these three foci worked as follows. As an initial stage of data analysis the corpus of material was read for the specific statements that had been chosen to explain anorexia nervosa. These statements were then considered as part of a disciplinary, discursive chain of such statements. In other words, the reference to previous interpretive statements and explanatory theories concerning the same phenomenon that appeared explicitly or implicitly within the article, book or book chapter were considered. This analysis of intertextual reference allowed a picture to emerge of those types of statement that are preferred within a specific discipline and are being used to explain both anorexia and construct gender. Finally, the pictures and discussions of art work produced by anorexic patients were analysed. In the published academic materials within the field of art therapy, the presentation of preferred interpretive statements is made in relation to pictures made by anorectic patients. The presence of both the picture and the interpretive statement made the specific ways of constructing anorexia nervosa clear. Thus the overall analytical procedure consisted of analyzing the presented picture considering plausible interpretations of this picture and considering the ways in which the meaning of this visual representation is presented by the researcher in this specific published article.

In relation to the field of psychiatry, while some principles from the analysis of art therapy were retained the actual process of analysis was different. Since an extended analysis of the ways in which anorexia nervosa has been explained in the fields of psychology and psychiatry had already been conducted by Malson (1998) the first form of analysis which addressed the corpus of 101 articles from three leading eating disorders journals was conducted by comparing each article to the taxonomy of explanations proposed by Malson (1998). This analysis allowed the major ways in which anorexia nervosa was being addressed to emerge and at the same time fulfilled the role of following the intertextual chain of reference. Thus in psychiatry the analysis of the ways in which anorexia nervosa is explained was based on the seminal analysis conducted by Malson (1998). A second analysis that was conducted resulted from the importance of the DSM as a document that directs disciplinary understandings of the concept of anorexia

nervosa. Accordingly, a series of specific articles which provided a review of published psychiatric research and made specific proposals for the revision of the definition of anorexia nervosa that is to appear in the latest version of the DSM V were analysed. Specifically the type of statements made, the chain of reference and the underlying construction of anorexia was considered.

4.3.5 Analysing the Construction of Women

A central aim of this dissertation is to explore from a feminist perspective the ways in which the definition of anorexia nervosa is gendered and the ramifications of this understanding on the way women are discursively constructed. Thus in relation to the analysis that appears in both disciplines the role of gender was analysed. This analysis was directed by the following specific questions:

1. How is the concept of woman used to explain the phenomena of self starving women within published disciplinary texts that address anorexia nervosa?
2. What specific definitions of the relations, roles and woman are presented within published disciplinary texts that address anorexia nervosa?
3. What gendered experiences are expressed within published disciplinary texts addressing anorexia nervosa?
4. What representations of women are present within published disciplinary texts addressing anorexia nervosa?

The analysis of gender also brought a critical aspect to the description of the anorexia in the different fields. In order to avoid the assumption that knowledge is neutral, part of the analysis involved critically interacting with the presentation, analysis and description of the ways different researchers in both fields explained anorexia nervosa. This critical interaction consisted of considering alternative ways of explaining anorexia based on existing critical literature as well as explicating underpinning assumptions which inform certain aspects of the presented definition of anorexia nervosa.

4.4 Shared and Differential Aspects of this Research Method

As outlined above very specific decisions were made in conducting the research presented in this dissertation. The method is informed by theoretical as well as methodological considerations and was quite complex. In each case decisions were consciously made in order to do justice to the richness of the data and the disciplinary

context. Art therapy and psychiatry share an interest in the conceptualization and treatment of anorexia nervosa and other mental health issues. But they are very different fields, with very different epistemologies, concerns and social status. Thus, the analysis of the construction of anorexia nervosa and women involved different decisions for each discipline.

The lack of standardization of the research method does not invalidate the results presented here or render irrelevant the final process of comparison between the disciplines. The difference in the methods results from carefully thinking about what needs to be done in each field to actually understand how the concept of anorexia nervosa is constructed. The shared aspects of the research design are that both studies use collected published academic literature as their core data; in each case the discursive disciplinary guidelines were considered for what they said about the concerns and considerations of knowledge creation in that field; for each discipline careful consideration of specific academic materials and the way they constructed anorexia nervosa and women was conducted; and finally critical, feminist considerations were applied to the conceptualizations of anorexia nervosa and women in both fields.

Ultimately, this context-sensitive method produced results that allowed the consideration of how anorexia nervosa and women are constructed in the disciplines of art therapy and psychiatry. The way to assess any proposed research method is to ask the question: does it allow you to answer the question posed in a systematic and academic manner? In the present case and in my evaluation, the method proposed here did allow systematic and valuable evidence to emerge that can be used to answer the questions at the heart of this dissertation.

Chapter Five

Diagnosis, Science and the DSM: Constructing the Power of Psychiatry

5.1 Introduction

Chapter Two of this dissertation analysed a specific case of interaction between psychiatry and art therapy. Through an analysis of the article written by Frisch, Franko & Herzog (2006) the role of the discourse of science in negating and marginalizing art therapy research was discussed. In this chapter, and as a precursor to the analysis of the construction of anorexia nervosa in the psychiatric literature in the 21st century that appears in the next chapter, the way psychiatry has constructed its discursive power base will be analysed. The approach taken here is partly historical and partly theoretical and aims to further explicate psychiatry's discourse of power situated in a very specific way of utilizing scientific discourse. Understanding this discourse is crucial. As already seen in Chapter Two, it is a core aspect of the discourse of psychiatry and directs many of the ways in which knowledge is constructed and delimited. As will be discussed in the next chapter, the field of psychiatry has made particular choices in relation to which statements are allowed in relation to the construction of the concept of anorexia nervosa. The aim of this chapter is to provide some insight into the nature of psychiatric discourse and the reasons why specific statements and not others are deemed significant and as knowledge.

5.2 The Discursive, Disciplinary Power of Psychiatry

Succinctly stated, my argument is that the power of psychiatry as a discipline rests upon three interlinked discursive constructions: 1) the centrality of diagnosis for medical discourse; 2) the centrality of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for the construction of psychiatric medical diagnoses; and 3) the underpinning rhetorical importance of science and positivist research methodologies in promoting or negating specific knowledge that can contribute to definitions within the DSM and to the process of diagnosis. Together these three components create a power structure which forefronts psychiatry as a discipline and the knowledge produced within the field of psychiatry. As with other mental disorders the psychiatric understanding of anorexia nervosa is tied to the way these three discursive forces function in promoting a very specific set of propositions concerning anorexia. As opposed to knowledge constructed in the field of art therapy, the ramifications of the psychiatric definition have broad effects across the realm of social action in relation to how anorexia is understood, presented, treated, legally evaluated and financially addressed. In the sections below, each of these three discursive components will be analysed and discussed in more detail.

5.3 The Centrality of Diagnosis

Mezzich, Kleinman, Fabrega and Parron (1996) all of whom are psychiatrists and in a book that considers culture and psychiatric diagnosis make the following observation at the very beginning of their introduction:

> "Diagnosis is a central concept in psychiatry and medicine. It defines the core of the domain of the field, and as Feinstein (1967) has pointed out, it establishes the patterns according to which clinicians observe, think, remember and act." (p. xvii)

Of particular importance here is the idea that at the heart of psychiatry is the social and conceptual process of diagnosis and that this process directs how other clinicians act and think. In other words, the process of diagnosis is a central tool of conceptual and material control and as such directs how a phenomenon will be understood and clinically addressed. Diagnosis is a central component of the discursive structures which support psychiatry's position and ability to promote particular understandings of anorexia.

Bourdieu (1991) offers some critical tools through which the power of diagnosis can be analysed. In a discussion of institutional power, Bourdieu (1991) observes that "the most rigorously rationalized law is never anything more than an act of social magic that works. Legal discourse is a creative speech which brings into existence that which it utters" (p.42). The point that Bourdieu is making is that it is through language that power is enacted. The power of language to classify and distinguish is also the power to dominate and control. The specification of a law or a social class is an act of 'social magic' that establishes an interpretive linguistic entity as a social reality with real world ramifications such as the acceptance or denial of sanctioned privileges. In this sense, the act of diagnosis in the field of psychiatry is first and foremost an act of social magic. It is 'magic' in that through the specific definition and classification of an illness, disorder, condition or syndrome a set of symptoms in an individual person is transformed into a medical event. The magical act of diagnosis has very real ramifications. Once a patient is diagnosed and labelled the institutional machinery of the health care system (and in some cases the state social services) rolls into action providing those services defined within the classification of the diagnosis. For the person diagnosed a series of new identities is immediately provided ('the patient', 'the mentally ill', 'anorectic'...etc). For the family of the newly diagnosed patient new understandings of the 'condition' of the family member are immediately made available. Once the magic of diagnosis has been worked, the world of the diagnosed patient is altered.

Psychiatrists and other medical practitioners do not see their diagnostic work as an act of magic. Quite the opposite is true. Medical diagnosis perceives itself as an act of scientific discourse which infers diagnoses based on the presence of measurable symptoms (an issue that I will address in more detail in section 5.5 below). Suopis & Carbaugh (2005) analyze the form of diagnostic discourse in the following way:

"- X (a disease, illness or condition) is something P (a person or organism) gets at point Z
- X is caused by agent C
- X is known because of symptoms (1,2,3, n)
- Therefore, P has X
- Given that P has X, treatment T is given." (p.265).

As can be seen here, the abstract form of the medical diagnosis has the structure of a logical inferential argument in which evidence is used to reach conclusions. However, a close look at this structure also reveals layers of hidden assumptions that inform the nature of the evidence that is collected. For example, Suopis & Carbaugh (2005), using Mishler's (1984)[1] analysis of the 'voice of medicine', point out that this form of the diagnosis rests upon the assumption that illness is situated in the individual and that diagnosis requires a systematic set of known symptoms. A diagnostic inferential system based on the assumption of individual illness denies (without using any evidence) positions such as Hogan's (1997) that a client's symptoms are a response to social norms and not merely an individual illness. Hogan points out that illnesses also function as metaphors, speaking expressively about disconcerting aspects of social life. It should be noted, that the feminist position taken by Hogan (1997) is not denied because evidence is against it, but rather because it does not fit nicely with the a-priori ideological assumptions of this specific medical diagnostic argument structure which situates all illness in the individual (reflecting a Western preference for individual accountability). The presence of a logical inference and observed evidence in an argument does not in any way mean that the argument is objective and beyond the cultural and historical context within which it is constructed.

Recent interdisciplinary work has attempted to critically investigate the process of diagnosis as cultural practice (Felson-Duchan & Kovarsky, 2005). These researchers see diagnosis as a central component of Western culture that is pervasive and a core component

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[1] Mishler (1984) conducted an important study of how medical interviews are conducted. Mishler (1984) states that 'the voice of medicine reflects a technical interest and expresses a scientific attitude. The meaning of events is provided through abstract rules that serve to decontextualized events, to remove them from particular personal and social contexts' (p.104. quoted in Soupis & Carbaugh, 2005).

of institutional power. As defined by Felson-Duchan & Kovarsky (2005), medical diagnosis is a process through which a collection of symptoms in the here and now of the patient is characterized as a disease. Once this diagnosis has been determined the specific causes are inferred and future treatment options are defined. Diagnosis plays a crucial role in this framework in that the explanation of the past (i.e the causes) and the direction of the future (i.e treatment) are tied to the process of making a diagnosis (Felson-Duchan & Kovalsky, 2005). As opposed to the common perception of diagnosis as an objective, decontextualized scientific activity, Felson-Duchan and Kovalsky (2005) state that "diagnoses and diagnostic thinking are cultural constructions" (p.2) and Trix (2005) succinctly describes diagnosis as 'a form of social reasoning, an authoritative naming practice, an evaluative discourse with consequences' (p.242).

Diagnosis is one of the main ways powerful institutions in societies maintain their power and from a feminist perspective maintain the power structures which have advanced men. Bourdieu (1991) states this process in the following way:

> "Social essence is the set of those social attributes and attributions produced by the act of the institution as a solemn act of categorization which tends to produce what it designates. The act of the institution is thus an act of communication, but of a particular kind: it *signifies* to someone what his identity is, but in a way that both expresses it to him and imposes it on him by expressing it in front of everyone and thus informing him in an authoritative manner of what he is and what he must be" (p121).

In this sense, the diagnosis itself functions as a personal conceptual and social schema that provides an explanation of the patient's symptoms that have been observed or reported. As a conceptual schema once the diagnosis has been made a range of additional meanings are immediately applied to the patient. The diagnosis presents itself as an objective representation supported by the authority of the scientific method and accordingly the associations of the diagnosis are also seen as self evidently valid. Essentially, the diagnosis functions as the central component in the construction of an explanatory narrative concerning the patient's past and future life and creates an identity for the patient which has both personal and social ramifications. Fadiman's (1997) book on cultural understandings of epilepsy shows how the diagnosis of epilepsy in the Hmong people brings with it a high status of access to hidden worlds and meanings, making the epileptic a special person who may wish to become a shaman. This positive social ramification stands in stark contrast to the social outcomes of the designation of a person as epileptic in Western societies. From the

perspective of this research project, diagnosis is seen as a contextualized, disciplinary, cultural practice that through its discursive function in society constructs a high hierarchical status for whoever controls the process of diagnosis. In relation to medical decisions, doctors provide diagnoses and in the cases of mental disorders psychiatrists play a central role in making diagnoses. Thus, the discipline of psychiatry through the promotion of the social importance of diagnosis constructs a central role for its own knowledge in defining mental phenomena.

5.4 The Centrality of the DSM

The Diagnostic and Statistical Manual of Mental Disorders has become a ubiquitous component of the treatment, diagnosis and research of psychological phenomenon in the US and in many other countries around the world. In the introduction to the DSM IV, the authors state the following:

> "The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills" (American Psychiatric Association, 1994, p. xxvii).

In this introductory comment, the coordinating task force of the APA who is in charge of the writing of the DSM IV, delineate several aspects of the DSM that are important for our present discussion of how the field of psychiatry created and maintained power for itself. In the last section, the social power of diagnosis was discussed; here, in my discussion of the DSM the way in which diagnosis is controlled by a small group of psychiatric specialists will be explicated. In this quote, the authors explain that the DSM is designed to provide directions concerning how to make a diagnosis and that the usage of this method has enhanced the standardization of proposed diagnoses. The presence of this diagnostic manual is applauded for its ability to decrease diversity of opinion and force those making diagnoses to follow a predefined set of options. Thus the DSM is seen as a way of limiting and controlling the diagnostic decision making process of acting professionals. Secondly, as specified by the authors, in order to make a diagnosis using the DSM, specialized training is needed. In other words, the realm of DSM diagnosis becomes a restricted area in which only experts can contribute. This makes diagnosis with all its significant personal, social, legal and economic ramifications the property of a small group of specialists with very specific qualifications. Thirdly, the focus on a particular specialization and the centralization of

knowledge into one manual creates a hierarchy of knowledge in which only the knowledge that enters the manual is actually considered of value. Thus, whoever controls the type of knowledge that is acceptable for inclusion in the manual also controls the status of knowledge within the wider field of clinical treatment, research and ultimately public perceptions.

The DSM has not always had a central role in controlling diagnostic activity and knowledge in the field of mental health. The power of the DSM can be traced back to specific changes made to the third version of the DSM in the 1980s. Kirk and Kutchins (1992) two social workers who have conducted several critical analyses of psychiatric diagnosis describe the process through which the field of psychiatry acquired power for itself through the production, dissemination and enforcement of the DSM. Kirk and Kutchins (1992) argue that the production of the third version of the DSM resulted from an attempt by the field of psychiatry to respond to the negative and, on the whole, lowly position they held in the hierarchy of knowledge and decision making in relation to mental health issues in the 20th century. Psychiatry had faced attacks on its professionalism on several fronts:

- psychiatric facilities were seen as crowded, inadequate and in some cases involving inhuman treatment (Rothman, 1971);
- psychiatric treatments based on psychoanalysis were seen as ineffectual and incapable of offering healing to sick patients (Eyesck, 1952; Szasz 1960);
- professionals such as clinical psychologists, social workers, nurses and others offered equally successful options for treating mental patients thus encroaching on what psychiatrist thought of as their professional territory (Castel, Castel & Lovell, 1982);
- the capability of psychiatrist in functioning as expert witnesses in court was questioned (Faust & Ziskin, 1988; Kittrie, 1972);
- and most importantly the ability of psychiatrists to make clinical diagnoses that differentiate the mentally ill from other people was directly questioned (Scheff, 1966; Szasz, 1960, 1961).

It is this last point, the difficulty over diagnostic differentiation that caused the deepest problems for the field of psychiatry. If an area of medicine cannot even define when someone is actually ill and what the nature of that illness is, then the very basis for defining the field is in question. To further compound this problem for psychiatry, the proponents of change (and ultimately the developers of the new DSM III) established the core problem of psychiatry as an inability to conduct reliable diagnoses (Spitzer & Fleiss, 1974). Thus even if there were effective definitions of mental illness, their application in the process of diagnosis was found

to be highly problematic as there was low inter-rater agreement over the diagnosis. Specifically, different psychiatrists were producing different diagnoses for the same patients.

In a historic rhetorical move, the production of the DSM III utilizing a new conception of the organization and procedure of diagnosis offered a solution to the problem of reliable diagnosis. Seeing the issue of diagnosis as a technical issue, psychiatric diagnosis which had been based on aetiology was in the third version of the DSM grounded in symptomology. This shift was a significant departure for psychiatry from previous attempts to organize diagnostic information and focused on the explicit symptoms that could be observed rather than hidden historical causes. Robert Spitzer who directed the changes to the DSM III presented the revised version as an "atheoretical" diagnostic system, based on scientific evidence and directing diagnosis through explicit observable behaviours. This shift countered what had been the accepted orthodoxy of psychiatry based on Freudian understandings that symptoms were symbolic representations of underlying causes and that it was these core causes that needed treatment. By focusing on explicit symptoms of patients as core diagnostic criteria and by demanding changes in the way the diagnostic interview was conducted, it was assumed than a much greater degree of agreement could be achieved in psychiatric diagnosis. Thus the core attempt of the DSM III was to increase the reliability of psychiatric diagnosis.

The change in the DSM III was directed by a small group of psychiatrists who specialized in nosology and diagnostic criteria and based themselves on a very particular conception of psychiatry and psychiatric diagnosis. The clearest rendering of this specific way of constructing psychiatry was produced in an article by Klerman (1978) that was influential in underpinning the approach to the DSM III and outlined what are known as Neo-Kraepelinian criteria. These criteria return to an early competitor of Freud, Emil Kraepelin who at the end of 19th century defined a system for identifying disease based on explicit signs and outcomes. Kraepelin's approach to diagnosis was based on biological approaches to classification that involved careful extended observation of the onset, symptoms, development and outcome of a psychiatric illness (Compton & Guze, 1995). As defined by Klerman (1978) the field of psychiatry and the practice of diagnosis should be based on the following positions:

1. "Psychiatry is a branch of medicine.
2. Psychiatry should utilize modern scientific methodologies and base its practice on scientific knowledge.
3. Psychiatry treats people who are sick and who require treatment for mental illness.

4. There is a boundary between the normal and the sick.
5. There are discrete mental illnesses. Mental illnesses are not myths. There is not one but many mental illnesses. It is the task of scientific psychiatry, as of other medical specialties, to investigate the causes, diagnosis, and treatment of these mental illnesses.
6. The focus of psychiatric physicians should be particularly on the biological aspects of mental illness.
7. There should be an explicit and intentional concern with diagnosis and classification.
8. Diagnostic criteria should be codified, and a legitimate and valued area of research should be to validate such criteria by various techniques. Further, departments of psychiatry in medical schools should teach these criteria and not depreciate them, as has been the case for many years.
9. In research efforts directed at improving the reliability and validity of diagnosis and classification, statistical techniques should be utilized." (Klerman, 1978; reproduced in Kirk and Kutchins, 1992, p. 50).

There are several important points of emphasis in this specific set of criteria. The emphasis on science, scientific methods, scientific knowledge and the role of statistics is designed to limit what can and what cannot be used as knowledge within the field of psychiatry. Specifically this emphasis distanced psychoanalytical and many psychological explanations (and is still used today as seen in Chapter 2 in the negation of knowledge from the field of art therapy). Second this set of criteria places an emphasis on medical and biological aspects of mental illness. Accordingly the area of expertise and the area that requires the most research are the medical aspects of mental phenomenon. Third, in relation to diagnosis, the emphasis is on the ability of psychiatrists in being able to clearly differentiate the mentally ill from the healthy and one mental illness from another.

The change to the diagnostic method of the DSM III was a major success as reflected in the numbers of sales of the revised DSM III, the reference to this manual in published research articles and books, and the usage of the manual and its criteria by health insurance agencies and other official and federal bodies. At the time of the writing of this manuscript it is difficult to think of diagnosis in terms that do not address the criteria proposed in the DSM. The reinvention of the DSM III rescued psychiatry through its rhetoric of scientific reliability, even though subsequent analyses of the ability of psychiatrists to make reliable diagnoses (supposedly the core reason for changing the DSM in the first place) did not show that greater reliability in diagnosis was actually achieved (Kirk and Kutchins, 1992; Lieberman & Baker,

1985; Melsop *et al.*, 1982). Furthermore, in the examination of how diagnoses were conducted by psychiatrists using the DSM III framework, the core idea of the Neo-Kraepelin diagnosis that doctors would be able to make clear distinctions between mental diseases in their diagnoses was found to be inaccurate with psychiatrists assigning several and different categories to patients leading to what Cohen, March and Olsen (1972) term the "garbage can model of organizational choice" (p. 1).

The administrative and financial success of the DSM III did not mean that it was not criticized. Quite the opposite was true, and especially by those who had suddenly been disenfranchised of power such as psychologists and psychoanalysts who directly objected to the new changes. Shortly after the revealing of the DSM III at a conference entitled "*DSM-III in Midstream*" in St.Louis in 1976, Berk & Jaso (1976) circulated a letter to the developers of the DSM-III and the leaders of the APA criticizing the oversimplification and restriction that characterizes the new approach in diagnosis and its bias towards biological aetiology. Similar criticism were presented at a later date with the medical and biological emphasis of the DSM-III described as reductionist and over-simplistic (Vaillant, 1984) and a case of psychiatry losing the concept of the mind (Reiser, 1998). However, the rhetoric of science combined with the power of the structure put in place with the DSM III, which provided criteria which researchers, the health insurance industry and governments could use, meant that the arguments against the DSM basically failed to make serious changes to the enterprise. DSM III placed the field of psychiatry in a central position to direct what consisted of knowledge and appropriate treatment in the field of mental illness. It is worth noting, however, one of the central criticisms of this manual was that this document confused the biological with the psychological and the social and this enacted a process of the medicalization of deviance. As stated by Rosenberg (2006), an historian of science, this process of 'medicalization' can be defined as "the tendency to recategorize sin(s) as pathology(ies) and to consign the management of such conditions to appropriately certified practioners" (p. 408). The changes in the DSM-III towards objective symptoms of patients marked a process in which the underpinning social and cultural aspects of the diagnosis were hidden and the status of the diagnosis was seen as representing a scientific reality rather than an act of social magic (as discussed above in section 5.3) influenced by social hierarchies.

Specifically for the concerns of the current study, the process of medicalization and emphasis on 'science' and biology obscured the inherently gendered nature of diagnosis. As argued by the feminist analyst Russell (1994) by situating diagnosis in the individual and focusing on explicit observable behaviours, social and contextual factors are ignored and

women's behaviours are defined as mental illness (rather than social responses – see also Hogan, 2001). While the DSM III and its later manifestations the DSM III R and the DSM IV may have had remarkable success in directing clinical diagnosis and the construction of knowledge concerning mental illness, this does not result from the validity or nature of its content but rather from the scientific rhetoric and centralization of power within a specific document. It is this aspect of a wider movement of the centrality of science in the late 20th century post-industrial world that will be addressed in the next section.

5.5 The Rhetoric of Science

In this section the third interlinked discursive force that constructed the power of psychiatry will be discussed. The power of psychiatry through diagnosis and the DSM is intrinsically tied to the usage of a specific form of discourse – the discourse of science. As seen in the Neo-Kraepelinian criteria proposed by Klerman (1978) and used as the basis for the development of the new DSM III and the overhaul of psychiatric diagnosis, the concept and rhetoric of science is given a central position. The specific usage of this rhetoric is as a tool of negation allowing one particular type of statement to be given preference and authority while other statements built upon different principles are marginalized. In fact, all of the Klerman's (1978) criteria presented above can be seen as a conceptual and rhetorical tool designed to provide its writers (and by extension the field of psychiatry), a position of power to control the types of statement that can be given prominence within medical discourse. This movement, by the rewriters of the DSM, towards the rhetoric of science as a way of gaining power is not by chance but rather reflects the wider position of science and scientific discourse within the late 20th and early 21st centuries.

As argued by Michael Zerbe (2007) a rhetorician of science, scientific discourse is the most powerful of all discourses in our present times. It is the place at which criticism is stopped by the impregnability of the scientific prose itself and the assumed authority of scientific statements. In a theoretical social analysis of the power of science, Bourdieu (2004) describes the historical mechanisms that led to this way of positioning science and provides a theoretical analysis which explains how this power is maintained. This position is briefly summarized below.

According to Bourdieu (2004) from the 18th century till the mid 20th century science enjoyed an ever increasing centrality and sense of autonomy as a field of human endeavor. The movement of disciplinary science towards a position of authority was gradual and the result of a series of specific social, physical, conceptual and discursive decisions made and accumulated through the actual construction of the different scientific domains. The result of

these decisions was the gradual differentiation of science and scientific knowledge from other realms of human activity. Bourdieu (2004) using Shinn (2000) offers an understanding of the distinctive aspects of the sciences. As a field of human endeavour, the sciences are characterized by the development of a series of very specific instruments, rationalized ways of thinking and problem solving, standardized protocols of procedure, epistemologies of knowledge creation, rules of experimentation and investigation and established factual knowledge. Accordingly, on a very basic level participation in the field of science involves accurate and extensive knowledge of all the accumulated aspects of the scientific domain. One needs to be competent to participate in a serious scientific discussion concerning the status of scientific knowledge. This by definition is a lengthy endeavour and classically what is considered under the heading of education. This is also the process through which symbolic capital in the form of a specific form of knowledge – scientific knowledge – is acquired. Basically, the process of learning science involves the internalization of a set of specific principles of knowledge construction, a form of habitus that directs functioning and understanding within this community and relations with other communities.

Another significant aspect that distinguishes the sciences is the position of the knowledge creator in relation to the knowledge created. This agent's disposition is elegantly described by Bourdieu (2004) through the use of the concept of the gentleman. The reference to a man as opposed to woman is not by chance. As described by Shapin and Schaffer (1985) in previous eras, science was conducted in the parlours of gentlemen. The importance of the gentleman was his position as a 'disinterested' party. As someone who was independent and honourable, the gentleman could testify to the quality of the fact that was discovered. This aspect of 'disinterest' is central in that the scientific knowledge that is constructed is supposed to be objective. Hardwig (1991) points out that scientific epistemologies are on the whole an attempt to extract the issue of trust from the process of constructing knowledge. In terms of a scientific field, following the procedural protocols and accepted epistemologies ensures that the knowledge constructed is worthy of consideration and acceptance. The conceptual movement is from trusting the individual researcher as a human being to the acceptance of the value of the established protocols of the field: from the personal to the bureaucratic.

To further differentiate the field of science it is worth considering the role of mathematics. As discussed by Bourdieu (2004), the historical progression towards the situation of autonomy for the sciences resulted to a large extent from the role of mathematics. As a starting point the role of mathematics in science created a situation in which specialized

ways of reasoning and thinking were required to participate in the field of science. Knowledge of mathematics functioned as a very basic 'gate keeper' for entry into the field. More significantly mathematical thinking changed the concept of explanation (Bourdieu, 2004). Rather than the use of rhetorical force and verbal exposition, mathematically calculated predicted outcomes and probabilities functioned as explanation. Finally mathematics as an explanatory tool deals with abstract relationships. In the field of sciences this led to the situation in which science became the manipulation of symbols not directly accessible or understandable to the wider public. According to Bourdieu (2004) the use of mathematics in science essentially distanced scientific knowledge from the wider public who did not have the required mathematical understanding.

As briefly described above, the increasing specificity of the knowledge required to participate in the field of science created the situation in which only other members of the same scientific discipline (and increasingly within very specific sub-sections of specific disciplines) could actually evaluate knowledge constructed within the field. This cut off the specific field of science from other human endeavours creating a self-justifying and partially closed system. It was possible to join the field but only at the price of extensive education and acceptance of the core principles and habitus of this community. Thus the fields of science looked inward for both evaluation and innovation – only other members of the same field (and in many case sub-section of the field) could provide accountability and direction. Within a modernist perception of the world which deeply respected the idea of rational progression this autonomy was uncontested and unproblematic. It was accepted that expertise did indeed infer authority and respect.

The outcome of this process of autonomy construction for the sciences was the expectation that knowledge created within the field of science by an active scientist should be regarded as privileged knowledge. The scientist was to be considered an authority and what the scientist testified to was to be considered accurate, informed knowledge backed by the authority of science in its entirety. The assumption was that the research scientist honestly working within the guidelines and protocols of his chosen scientific field created knowledge that should not be disputed by anyone except another fully qualified competing scientist in the same field.

This way of constructing science and the scientist meant that the discourse of science had become a powerful rhetorical tool in promoting or negating very specific social agendas. This process is exemplified by what happened in the US towards the end of the 20th century. In the 1980's in the US and in the fields of interest to society such as education and medicine

the rhetoric of scientific discourse was used extensively. For example, in education a series of requirements for the restriction of knowledge to quantifiable knowledge were enacted under the heading of the "No Child Left Behind" act during President Reagan's time in office. This provision distanced qualitative and art-based approaches to education and the construction of knowledge about education. The "No Child Left Behind" act required the testing of children in relation to quantifiable knowledge which transformed reading, for example, from a personal process of meaning construction to a process of analysing linguistic structures. In a similar move, the new DSM III drew upon the same discourse of empirical, quantitative science to deliver a new way of conducting diagnosis. As described above, these focused on the Neo-Kraepelinian criteria for psychiatric diagnosis. These parallel phenomena reflect a zeitgeist of using scientific discourse for the rhetorical aim of controlling knowledge. Without the background of the importance of the discourse of science in the later 20th century, it is doubtful that the specific proposals made by Neo-Kraepelinian proponents would have had the rhetorical, persuasive power that they had. It is important to note that the shift in power towards those who argued that they were using the scientific method did not actually mean that this was the case. For psychiatry there is ample evidence that on scientific grounds the writers of the DSM III conducted 'bad' science and made claims that far exceeded the nature of the studies themselves (Kirk and Kuthins, 1992). It was the usage of the rhetoric of science rather than the scientific method that created a specific power structure.

As argued above, the introduction of the DSM III in the 1980's was based on a very specific set of guidelines that positioned psychiatry in a central role in controlling the definition of mental disorders. This power to control knowledge was created through the social importance of diagnosis, the control of diagnosis through a very particular literacy product – the DSM which was defined using the rhetoric of science. Together, diagnosis, the DSM and the rhetoric of science created a powerful force for controlling which statements concerning anorexia nervosa were going to be accepted. In the next chapter we turn to the definition of anorexia nervosa that is currently being discussed and propagated by the field of psychiatry and is a continuation of the power structures put in place to support the centrality of psychiatry through the control of psychiatric diagnosis.

5.6 Chapter Summary: DSM and the Power of Psychiatry

The outcome of the theoretical and historical analysis that appears in this chapter is the understanding that the power of psychiatry is tied to the role of diagnosis and a specific usage of the discourse of science. The DSM plays a central in constructing the power of

psychiatry as it is a document that is used to control the nature and content of diagnosis. As such the DSM can be seen as the prime document through which Foucauldian micro-physics of power is enacted. On a daily basis, diagnosis by diagnosis, the power of this document is apparent as vast numbers of patients are diagnosed and categorized according to the guidelines set out by the small group of psychiatrists entrusted with defining each mental disorder. From the perspective of this dissertation, a close consideration of the DSM manual in relation to anorexia nervosa can reveal the specific decisions about legitimate knowledge within the discipline of psychiatry concerning the concept of anorexia nervosa. In the next chapter, the way in which the concept of anorexia nervosa is understood and conceptualized within psychiatry and in the 21st century will be addressed. Based on the analysis in this chapter, this will be achieved by considering the current DSM and discussions of the revision of this document that are currently being conducted in addition to a consideration of the range of explanations of anorexia nervosa present within the academic literature of psychiatry.

Chapter Six

The Disciplinary Construction of Anorexia Nervosa in Psychiatry in the 21st Century

6.1 Introduction

The aim of this chapter is to present new evidence relating to the way anorexia nervosa and women are constructed within the discipline of psychiatry in the 21st century. In order to discuss developments in the 21st century, the chapter starts by reviewing the way in which anorexia nervosa has been constructed historically. Following and building upon this historical analysis, two new studies of collected corpuses of materials within the framework of psychiatry will be presented and analysed. The first study utilizes a taxonomy developed by Malson's (1998) and examines the types of explanation used in all the articles published concerning anorexia nervosa in three major psychiatric journals during the year 2009. As such this chapter goes beyond and updates the analysis conducted by Malson (1998) and the historical review of the construction of anorexia nervosa. The second study explores a series of articles published by leading psychiatrists who are involved in the current revision of the definition of anorexia nervosa that will appear in the new version of the DSM. As analysed in Chapter Five, the DSM fulfils a central role in directing the way anorexia nervosa is understood. As such this second study offers direct insight into the way knowledge is currently being constructed in relation to the concept of anorexia nervosa by leading psychiatrists.

These two studies build upon the analysis of the power of psychiatry as directed through the usage and control of the DSM (Chapter Five) and the taxonomy of types of explanation of anorexia nervosa developed by Malson (1998). The relationship between the two studies is based on Foucauldian ideas of evaluating the type of statements that are preferred and disseminated within a particular discourse. The first study presents some insight into the breadth of positions propagated within the research literature in 2009; the second study of current discussions concerning the revision of the DSM reveals choices made of specific types of statement that are being given preference and prominence with this influential document. Together these two studies answer the questions:

1. In what ways does the discourse inform and constrain the production of disciplinary explanations of the phenomenon of self starving women (termed anorexia nervosa) within the field of psychiatry?
2. How is the phenomenon of self-starving women (termed anorexia nervosa) explained by publishing researchers within the discipline of psychiatry?

3. In what ways are women constructed and represented within the predominant explanations of the phenomenon of self starving women (termed anorexia nervosa) within the discipline of psychiatry?

6.2 A Genealogy of Anorexia Nervosa: A Review of Malson (1998)

My work in this dissertation which extends previous poststructural analyses of the term anorexia nervosa is greatly aided by the fact that an extensive and truly exemplary analysis of the construction of anorexia nervosa within the field of psychiatry has already been conducted by the feminist, poststructuralist critic Helen Malson (1998). Accordingly, the aim of this review section is to present the core historical and categorical understandings of Malson (1998) as a backdrop to the work that I will use as an analytical and comparative tool in the later sections of this chapter and dissertation. As stated by Malson (1998) her aim is to discuss a "genealogy" of anorexia and examines how "anorexia has been discursively constructed as a clinical entity" (p.7).

Malson (1998) constructs her poststructuralist review of the genealogy of anorexia nervosa within the context of a history of discourses that continually pathologize women. The nature of the specific pathology or how it is explicated changes during different periods but the core principle of seeing women as pathological has deep historical roots and represents a gender-bias within a range of medical discourses. In this sense, Malson's (1998) analysis of the discursive construction of anorexia nervosa is underpinned by previous cultural analyses that link women with madness in the 18th, 19th and 20th centuries as presented in the seminal work of Showalter (1985) and Ussher (1991). Broadly, these studies explicate the discursive construction of women as 'othered' in relation to the rationality of man embodying the rationally-reversed characteristics of being mad, sick, irrational and intellectually impaired (Malson, 1998; Ussher, 1991). This way of constructing women is situated within a wider discussion of the patriarchal oppression that utilizes finely analytical critiques of discourse (including medical discourse) to naturalize the argument that women are inferior and the enforcement of a structure of social hierarchy. Thus, as with other poststructuralist histories, the basic principle of design is the exploration of the relationship between broader societal and medical discourses to establish the guidelines within which anorexia nervosa is constituted.

Malson (1998) situates the beginning of the medical description of anorexia nervosa as a transition from theological to scientific explanations of the world in the late 17th and early 18th centuries. Although other histories of anorexia nervosa have related to doctor's reports on anorexic type symptoms from the early 17th century (such as Fabricus 1611/1646

and Morton 1689/1694) and descriptions of self starving women in religious settings (such as the phenomenon known as "Holy Anorexia"), Malson (1998) argues that while these descriptions are medical they are not yet descriptions of anorexia nervosa. They can be seen as medical and other descriptions of extreme fasting and not the specific and constructed term anorexia nervosa. The medical concept of anorexia nervosa is tied to the development of a gendered concept of disorders related to the nerves and the pathologization of the female body in the 18th and 19th centuries. This process of seeing the female body as naturally pathological involved the construction of female developmental characteristics such as puberty, menstruation, pregnancy, childbirth and menopause as "causes of illness and pathological in themselves" (Malson, 1998, p. 57). In particular the ovaries and the female reproductive system were constructed as directly linked with mental illness a position that supported the concept of the natural lowliness of women (Hogan, 2006). Women, it was argued, had greater natural sensibility in the nerves thus rendering them susceptible to a range of nervous disorders. The concept of hysteria propagated in the 18th and 19th centuries was developed against this backdrop of gendered nervous disorders and seen as a disorder resulting from women's 'hypersensitivity' (Malson, 1998; Ussher, 1991). During the 19th century and with the advent of more mechanistic descriptions of the psyche, this concept of hysteria based on female hypersensitivity and a pathologized reproductive system was extended to pathologize and sexualize the whole of the nervous system producing theories of hysteria as suppressed feelings of sexual desire (see Freud and Breuer, 1895). This context of gendered disorders of the nerves, hysteria and pathologized female bodies presented the backdrop for the development of the concept of anorexia nervosa in the 19th century which I will now scrutinize in greater detail in the coming paragraphs.

In Malson's (1998) analysis the initial introduction of the concept of anorexia nervosa can be found in the publication of a paper by a French professor of medicine - Charles Lasegue (1873) - which was summarized in the same year in the prestigious English medical journal *The Lancet*. This paper, entitled 'Hysteric anorexia' created an important link between the cultural/medical concepts of hysteria and disorders of the gastric system. Specifically the physical, gastric disorder associated with anorexia was described as the outcome of feminine nervousness and a form of hysteria. Hysteria was presented as influencing every aspect and stage of the development of this defined disorder and 'hysteria anorexia' was situated as one of many forms of hysteria. Anorexia is gendered resulting from gendered understandings of nervous disorders and the female body. As specified by Malson (1998) throughout Lasegue's paper the patient is specified as a female who is "childlike" and

"mentally weak" (p. 62). The explanation of hysteric anorexia is based on, and has a reciprocal relationship with, a much broader discourse of gender description which describes women as sick and naturally inferior.

William Gull, a British physician subsequently (previously or concurrently depending on whose history we accept) in 1874 also published a description of anorexia nervosa. While there is continuing argument over whether Lasegue or Gull 'discovered' anorexia nervosa, the description promoted by Gull shares the same gendered assumptions as does the Lasegue paper. The physical aspects of anorexia nervosa were seen as a result of a nervous disorder to which women were assumed to be particularly susceptible. However, Gull's position shifted the cause of the disorder of anorexia from the uterus (*anorexia hysterica*) to the nervous system (*anorexia nervosa*). As analysed by Malson (1998) the specific terms used by Gull in his description of anorexic patients created a particularly negative picture of women. His descriptions included the concepts of women as having a "mental perversity", "peevish tempers", "unsound mind", "mind weakened" and "temper obstinate" (p.68). In particular the pathological nature of women and their assumed inherent 'weakness of mind' constructed for Gull and other practitioners the perception that treatment should be conducted along patriarchal lines in which the female patients were not to be consulted or taken into consideration in any way. Gull's approach to treatment involved overcoming the "wilful" nature of these patients by feeding them at "regular intervals" and surrounding them with "persons who have moral control over them" (Gull, 1874, p. 26; reproduced in Malson, 1998, p. 69). As with other aspects of the construction of anorexia nervosa this aspect of treatment can be seen as reflecting and contributing to the wider social patriarchal discourse arguing for control over women.

As argued by Malson (1998), Lasegue and Gull's papers situated anorexia nervosa as an object of medical discourse. Following the publication of these papers, subsequent work by Gull (1888) and others clearly marked the entry of anorexia nervosa into the medical literature. Before the end of the 19th century, the term anorexia nervosa "appeared quite regularly in the medical press" (Malson, 1998, p.70). There were broad guidelines of agreement concerning the nature of anorexia nervosa: the symptomatology of anorexia consisted of systematic starvation resulting from an aversion to food; this aversion was not an organic disease but rather a nervous disorder; the susceptibility of young girls to nervous disorders made anorexia nervosa a gendered, feminine disorder. According to Malson (1998) disagreements among authors related to what types of nervous disorder was being addressed

– was this "hysteria, neurasthenic[1] or nervous" (p.71). But the basic construction of the "nervous woman" stayed as a constant underpinning concept.

There was also disagreement concerning the moral state related to anorexia nervosa. As analysed by Malson (1998) the "subject of 'anorexia nervosa' was thus produced as perverse, mentally weak, irrational, obstinate, and childish; even as deceitful, selfish, vain and spoilt" (p.72). This psychological and moral description of women was used to justify and reinforce treatments advocating the control of women. These treatments could be horrific involving a range of "misogynistic 'cures' including the bleeding of genitals and breasts, clitoridectomies and ovariotomies", "bed rest", and "forced feeding" (Malson, 1998, p.73). The treatment of anorexia in this way constructed a form of double standard in which the female patient is presented as naturally mental incapacitated but at the same time is wilful and obstinate and in need of moral control and punishment to bring her to appropriate submissive behaviour. These features and approaches to the treatment of anorexia nervosa within the 19th century were produced within the wider social, biological determinist discourse of woman's mental weakness and susceptibility to nervous disorders. The treatments directly influenced and were informed by wider political arguments for the need for patriarchal control over women. The medical discourse of anorexia nervosa integrated the broader societal concepts of women and reinforced existing ideas about women and how they should be treated.

Medical discourse in the 20th century was characterized by the development of a series of technological and conceptual innovations that led to a range of new knowledges. As described by Malson (1998), at the beginning of the 20th the concept of anorexia nervosa was appropriated and discussed within the medical literature of psychoanalysis. This approach to the explanation of anorexia nervosa explored the symbolic meanings of anorexic symptoms but emphasized the relationship between sexuality and eating. As described by the social historian Joan Brumberg (1986), anorexia nervosa was constructed as a form of neurotic defence against the onset of sexuality in women and as a case of "poor heterosexual adjustment". However in parallel to the development of symbolic psychoanalytical explanations of anorexia nervosa, scientific research under the heading of logical positivism influenced medical discourse. From a logical positivist position psychoanalysis was a

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[1] Neurasthenia was a mental disorder invented by George M. Beard in 1868 and defined as "a chronic functional disease of the nervous system, the basis of which is impoverishment of nervous force, waste of nerve tissue in excess of repair, hence the lack of inhibitory or controlling power physical and mental, the feebleness and instability of nerve action and the excessive sensitiveness and irritability, local, general direct and reflex" (Beard, 1888, p. 157 quoted in Ferraro 1954, p. 299). This disorder was primarily diagnosed for women.

problematic theory and accordingly more physiological explanations were promoted (see for example, Kaplan & Woodside, 1987). These included explaining anorexia nervosa as a form of endocrinal dysfunction (Halmi, 1987) or as a form of hypothalamic dysfunction (Russell, 1977). This and other similar explanations (see the next section) reconstituted anorexia nervosa as a form of physical disease. The influence of logical positivist positions on diagnosis and the definition of anorexia nervosa has already been elaborated (see also Compton & Guze, 1995). By the 1940's theories which addressed both psychological and physiological explanations emerged under the heading of 'psychosomatic disorders' (Malson, 1998). These different discourses produced a range of different and very specific knowledges concerning the nature of anorexia nervosa. The next section provides a review of the different ways in which anorexia nervosa was constructed in the 20th century.

6.3 Malson's (1998) Classification of 20th Century Explanations of Anorexia Nervosa

As discussed in the previous section, the 20th century presented a range of new technological and conceptual options for defining and explaining the concept of anorexia nervosa. In order to conceptually organize these diverse ways of understanding anorexia, Malson (1998) constructed a form of taxonomy based on different core ways of understanding anorexia nervosa. As stated by Malson (1998), her aim in creating this taxonomy of options was "to explore the multiplicity of twentieth-century knowledges and 'truths' of 'anorexia nervosa'" (p. 76). As such this taxonomy serves the current study by providing a comprehensive overview of the different directions taken within the psychological and psychiatric literature in constructing anorexia nervosa. Accordingly, the categories of explanation in this taxonomy are presented and explicated below.

6.3.1 Anorexia Nervosa as a Natural Disease Category

In this category of explanations, anorexia nervosa is explained as resulting from underpinning biological variables. Studies in this category consist of biomedical research into "physical variables including dermatological, cardiovascular, gastro-intestinal, endocrine, neurophysiological, thermoregulatory and musculoskeletal abnormalities" (Malson, 1998, p. 78). The underpinning conceptual understanding of this approach is that a core "biological pathogenic variable" (Kaplan and Woodside, 1987) will be discovered that will explain the phenomena of self starving women. The attempt is to construct anorexia nervosa as a natural, physiological disease and accordingly, physiological variables need to be systematically defined and their causal relationship to anorexia nervosa established. According to Malson in her 1998 review of the literature, no core biological variable has actually been found for anorexia. In addition, the problem with the biomedical approach is that it restricts a broader

discussion of the nature of anorexia nervosa. The concentration on the physical body and empirically substantiated quantitative data, excludes examination of the discursive construction of anorexia such as issues of gender, socio-political contexts, psychological contents and mechanisms and issues of identity and experience. In addition, without any cognizance on the part of the psychiatric practitioners who conduct this research, this recreates the core assumption that women's maladies find their source in their physical bodies (Hogan, 2006; Malson, 1998).

6.3.2 Anorexia Nervosa as Genetic Predisposition

In this category, medical researchers have tried to establish a genetic inheritance as a causal explanation of anorexia nervosa. This research aims to define a genetic phenotype for anorexia nervosa which would explain the relationship between a specific and specified genetic composition and their interaction with environmental risk factors. Research within this framework has examined the presence of anorexia within extended families, parents and siblings and between twins (Holland *et al.*, 1984; Holland *et al.*, 1988; Strober *et al.*, 1985). As reported by Malson (1998) the results do not substantiate a genetic explanation of anorexia nervosa. This way of constructing anorexia nervosa can be seen as similar to the previous category, in that the attempt is to define a physiological basis for anorexia nervosa that would constitute it as a natural disease. Accordingly as with the previous category, this approach restricts discussion of other issues that could account for the phenomena of self starving women and is constructed against a historical predisposition to situate female maladies in the physical body of women.

6.3.3 Anorexia Nervosa as Affective Disorder

In this category, anorexia nervosa is explained as a variant of the defined affective disorder - depression. The basis for this connection consists of a number of shared symptoms between the two defined conditions (Strauss & Ryan, 1988). Some symptoms of depression such as insomnia and weight loss have been described in relation to anorexic patients and some of the symptoms of anorexia found in patients diagnosed with depression (Wolpert, 1980). This overlap in described symptoms has led some researchers to explore the interrelationship between these disorders and to assume that perhaps they find their source in a shared "organic aetiology" (Jampala, 1985). However, as stated by Malson (1998) this relationship is far from clear and there is no conclusive evidence that these two conditions are related. Furthermore, if there is an option of a connection between these two disorders it might be on the level of women's responses to socio-cultural constructs and not on the level of a biological underpinning cause.

6.3.4 Anorexia Nervosa as Cognitive Dysfunction

In this category, anorexia nervosa is explained as a form of cognitive dysfunction. Drawing on cognitive psychological concepts, patients with anorexia are constructed as having a range of cognitive deficits. The main problems studied and reported on consist of schemata relating to food and weight with anorexic women being described as preoccupied with food and overvaluing body mass (Vitousek & Hollon, 1990) and specific "cognitive deficits" and "dysfunctional beliefs" that result in self starvation behaviours (Clark et al., 1989, p. 377-378). Additional research from a cognitive perspective has addressed different cognitive problems including a lack of abstract thought (Bruch, 1962), poor cognitive performance (Strauss & Ryan, 1988), irrational beliefs (Ruderman, 1986), dichotomous all-or-nothing thinking, superstitious thinking and ego-centric thinking (Garner, Garfinkel & Bernis, 1982). As specified by Malson (1998) in relation to these cognitive functions results are inconclusive and to a certain extent contradictory with anorexic girls in some studies performing as well as or even better than the control groups. As with the underpinning assumptions of cognitive psychology, these specific cognitive problems are situated in the individual psyche of the anorexic patient without consideration of socio-political and other contextual factors. This approach to explaining anorexia nervosa is reductive and considers cognitive functions and processes as divorced from the social and environmental frameworks within which they developed. Thus, within these descriptions of anorexia, the patient with anorexia is defined as cognitively deficient and suffering from individual cognitive distortions. It is interesting to note that the specific list of cognitive dysfunctions is reminiscent of early manifestations of women as suffering from a range of 'rational' problems and returns to ways of constructing women as mad (Hogan, 2006; Showalter, 1985; Ussher, 1991)

6.3.5 Anorexia Nervosa and Body Image Distortion

In this category, anorexia nervosa is explained as a very particular form of cognitive dysfunction – a distortion in the perception of body image. This way of explaining anorexia is based on research that shows that anorexic girls incorrectly evaluate their body weight and overestimate their size (Bemis, 1979; Manley *et al.*, 1988; Steiger *et al.*, 1989). While they are emaciated, they consider themselves to be overweight. This issue of body perception is presented as central to the condition of anorexia nervosa and its treatment is seen as an important aspect of recovery. However, this overreaching research conclusion is problematic. As reported by Malson (1998) body image distortion may be limited to a mistaken evaluation of waist size rather than the whole body (Fichter *et al.*, 1986). In addition, in a study

conducted by Fairburn (1987) perception of body image was found to fluctuate within individuals over a four week period, suggesting that both context and mood may influence the perception of the body. Furthermore some research has shown that a distorted image of one's body may be widespread among women (Heilbrun & Friedberg, 1990) leading Malson (1998) to conclude that problems in the perception of body image may not be a defining characteristic of anorexic patients. As with other cognitive approaches the social context and cultural variables are ignored within this category of explanation.

6.3.6 Anorexia Nervosa as Familial Pathology

In this category, anorexia nervosa is explained as a psychological disorder that is situated within the context of a dysfunctional family. For this type of explanation, anorexia nervosa is both caused by interactions in the family and is maintained by this family context and relationships. Connections between the family and the development of anorexia are of several different types. Some research has considered the eating and weight behaviours of parents as a cause for adolescent anorexia nervosa and other eating disorders (Garfinkel & Garner, 1982). Other researchers have construed that there is a form of anorexic family in which certain characteristics of family discourse such as an emphasis on achievement, perfectionism, and control produce anorexic outcomes (Guttman, 1986). The nature of autonomy in the family and the degree to which anorexic girls are enmeshed or separated from other family members have also been considered as a potential cause of anorexia (Minuchin *et al.*, 1978). There has also been some research on the connection between child sexual abuse and the onset of anorexia nervosa (De Groot *et al.*, 1992; Waller *et al.*, 1993). All these approaches assume the importance of the family as a causal and supportive agent for the development of anorexia. But it is important to understand that families are themselves part of a much wider social-cultural system that manifests and embeds a wide range of cultural beliefs. Thus, as stated by Malson (1998) the 'anorexic family' "may simply be the bearer of our culturally sanctioned values" (p. 85).

6.3.7 Anorexia Nervosa as Psychodynamic Disturbance

In this category, anorexia is explained as a psychodynamic disturbance that results from problems in early child-parent relationships. The act of self starvation is seen in symbolic terms and described as a defence mechanism against the onset of adolescent sexuality (Sayers, 1988) and mature femininity (Plaut & Hutchinson, 1986). Explanations of the type of disturbance in child-parent relations tend to focus on the role of the mother and a degree of mother's blame is inherent in these explanations. Mothers have been blamed for not facilitating appropriate developmental separation between mother and daughter (Birksted-

Breen, 1989), for the development of the anorexics girl's lack of self esteem and control (Bruch, 1982), and for a failure to respond to the anorexic girl's needs and the imposition on the anorexic girl of the mother's fears and needs (Bruch, 1973; Palazolli, 1974). Broadly, in psychoanalytic terms, anorexia is seen as a result of an unresolved Oedipal and pre-Oedipal conflict which results in inadequate ego development and difficulties in the acceptance of the onset and physical presence of female sexuality. As argued by Malson (1998) this approach to explaining anorexia nervosa does not situate either the individual psyche or the family within a broader social-cultural context and uncritically describes the family within a specific set of gender roles.

6.3.8 Anorexia Nervosa as Restrained Eating

In this category, anorexia nervosa is explained as a phenomenon of dieting or restrained eating. The ramifications of this position are interesting in that anorexia nervosa is described not as a distinct category of women that is completely divorced from other women, but rather as part of a continuum of behaviours concerning eating. Research in this category has addressed the prevalence within society of women who are dissatisfied with their bodies and engage in varying degrees of restrained eating behaviours. This research suggests that large numbers of girls of all ages are struggling to become thinner and reduce their weight (Huon & Brown, 1984; Freeman *et al.*, 1983). This research suggests that many of the assumed identifying pathologies assigned to anorexic girls are actually shared with women within wider society and not unique to this population. As argued by Malson (1998) this approach to explaining anorexia nervosa may "undermine the disease model of anorexia nervosa as a distinct individual pathology" (p. 92).

6.3.9 Anorexia Nervosa in a Socio-Cultural Context

In this category, anorexia nervosa is explained in relation to the broader social and cultural context within which it appears. On a basic level, connections between the prevalent and insistent representations of thin women within the fashion industry and media outlets and the increased occurrence of cases of anorexia nervosa has been noted (Bordo, 1990; Casper, 1983; Polivy & Herman, 1987; Silverstein *et al.*, 1986a). The explicit and implicit construction of 'thin' and 'fat' women and the associated values and beliefs are seen as contributing factors that create a connection between social value and thinness in women that can be seen as an underlying factor in the development of anorexia nervosa (Richardson *et al.*, 1961). While these socially defined descriptions of female beauty have been seen as Western concerns, the processes of dissemination of cultural values and acculturation have transferred these values to a range of populations with the associated rise in cases of anorexia

nervosa (Pumariega, 1986). More sophisticated understandings of the social-cultural context of anorexia nervosa address the underpinning contradictions of post-industrial, consumer society in which individuals are pushed to be overabundant consumers of goods at the same time as self control is advocated (Gimlin, 1994). These contradictory messages can be manifest in the same magazine with slimming products situated directly next to articles promoting food products and the value of a curved feminine body (Sliverstein *et al.*, 1986b). In these explanations, anorexia nervosa is seen as a response to the inherent contradiction of post-industrialist society. The explicit representations of a preferred body type that is nearly impossible to achieve for the vast majority of women and a range of associated symbolic meanings assigned to this body type construct an impossible situation in which widespread dissatisfaction among women is nearly assured. In this context, anorexia nervosa can be seen as both a rebellion and submission at the same time; taking back control of the personal body shape and weight, taking this to its extremes (until death in some cases) and at the same time submitting to the socially signified importance of body weight and shape and the symbolic values assigned to this body type. Thus anorexia becomes a form of cultural response and reflection of the incongruity of the society within which anorexic girls live.

6.3.10 Anorexia Nervosa and Gender

In this category, anorexia nervosa is explained as a gendered phenomenon. From a demographic perspective, the statistics on the frequency of anorexia nervosa demonstrate that anorexia is predominantly diagnosed in woman suggesting a gender bias in relation to this diagnosis and phenomenon (Gowers *et al.*, 2010). Gender research in relation to anorexia nervosa has explored the relevance of unequal power relationship between genders in society and the family as a cause of anorexia nervosa (Chernin, 1983; Lawrence, 1984; Sayers, 1988) as well as the inherent problems and pathology of socially sanctioned and widely disseminated prescribed female roles. Some research has been directed at the changing gender roles that women are required to fulfil and the confusion and contradictions that this entails. Women are expected to be autonomous and compliant, independent and dependent, and sexually attractive and sexually neutral at the same time (Turner, 1992). Malson (1998) in her discussion of gender and anorexia nervosa points out that some of this discussion of confusing gender roles involves a subtext of criticism of second wave feminism. Malson (1998) points out that an alternative feminist perspective would be that second wave feminism did not go far enough in changing how woman are defined in society

Additional research on gender and anorexia nervosa has explored the backdrop of medical discussion connecting women with pathology (such as Ussher, 1991 or indeed

Malson 1998 herself). In these feminist, poststructuralist approaches to medical discourse, anorexia is one of several described disorders that have been attributed to women and are part of an oppressive patriarchal discourse. In relation to the usage of patriarchy as a cause for anorexia, Malson (1998) warns against explaining anorexia in relation to a single linear cause. Thus while patriarchy may play a role it is a much more complex interaction that results in the presence of anorexia.

6.3.11 Historical Limitations of Malson's (1998) Taxonomy

The taxonomy presented in the last section sets out a range of ways in which the phenomena of anorexia nervosa has been explained within medical discourse of the 20th century. Each of these explanations proposes a different orientation in explaining anorexia and together these approaches present a diversity of different ways of constructing anorexia nervosa. As argued by Malson (1998) the presence of different explanations of anorexia has led some to express the desire for a multidimensional approach that integrates all the different ways of understanding anorexia nervosa (Garfinkel & Garner, 1982). But these different approaches are not necessarily epistemologically compatible and as such integration is not really a possibility. For example, the emphasis on empirical data within the medical literature is epistemologically incompatible with the interpretive epistemology of psychoanalysis. Furthermore, as argued by Foucault (1972) the decision over which explanations are integrated and ultimately propagated as knowledge is tied to a much wider set of social and cultural power structures. This is not just an issue of academic integration of neutral knowledge. Each of these explanations comes from a disciplinary and socio-cultural context and has ramifications in relation to social power and how it is exercised.

An additional issue with this review is the historical limitation of Malson's work. Her work was published in 1998 and, as such, represents an analysis of the state of knowledge that existed up and until that point. Accordingly there is a need to see if these categories of explanation are still valid. However, the review of these categories of explanation of anorexia nervosa does have value in that it sets out a systematic taxonomy of ways of categorizing different explanations of anorexia.

6.4 The Construction of Anorexia Nervosa in Journal Articles in 2009

The last section presented a historical account of the development of the concept of anorexia nervosa within the psychiatric literature and presented Malson's (1998) taxonomy of categories of explanation of anorexia nervosa. This taxonomy set out a range of ways in which the phenomena of anorexia nervosa has been explained within medical discourse of the 20th century. However, Malson's (1998) review is tied to the historical period that she

researched and needs to be evaluated for changes that might have occurred since the end of the 20th century. I will move this research forward by considering two specific issues: 1) Have any changes taken place in the type of explanation proposed for anorexia nervosa since the end of the 20th century?; and 2) What characterizes disciplinary, psychiatric understandings of anorexia nervosa in the 21st century? The first question involves considering the breadth of research currently being conducted and the category of explanation that is being utilized. In particular the research is focused on trying to quantify current research directions and see if any new forms of explanation have appeared. The second question is aimed at seeing the specific orientation of the field of psychiatry in relation to this wide set of potential options for explaining anorexia.

6.4.1 Methodological Issues

The aim of this section is to update Malson's (1998) review of the ways in which anorexia nervosa has been explained within published medical literature. As an initial stage, a corpus of articles written concerning anorexia nervosa over the period of 5 years was compiled using academic, electronic search engines. The search term used was *anorexia nervosa* and the search was directed to look for this term in the title and abstract of the article. This process produced several thousand articles written in a wide range of different fields. The analysis of this corpus of materials would have been problematic in that it was not limited to medical literature and involved an expansive and unwieldy number of articles. Accordingly, a more focused approach was used in updating Malson's (1998) review. From a medical perspective, anorexia nervosa belongs to the category of eating disorders and therefore a search was conducted to find those journals which deal with eating disorders and are directed at the psychiatric profession. This search yielded three journals: the *International Journal of Eating Disorders*, the *European Eating Disorders Review*, and *Eating Disorders*. All three of these journals specify in their aims, goals and readership sections that their publications are directed at clinicians and researchers within the fields of psychology and psychiatry. Two of the journals are tied to established eating disorder organizations. The *International Journal of Eating Disorders* is the official publication of the Academy for Eating Disorders an organization that defines itself as "a global professional association committed to leadership in eating disorders research, education, treatment, and prevention" (AED – Academy for Eating Disorders) and whose members are deeply involved in the revision of the diagnostic criteria of the highly influential Diagnostic and Statistical Manual of Mental Disorders (DSM). The *European Eating Disorders Review* is the official publication of the Eating Disorders Association a British charitable organization (Registered

Charity No. 801343) aimed at overcoming eating disorders. Both these organizations have associated conferences. However, while the Eating Disorders Association allows anyone to attend its conference, attendance of the Academy of Eating Disorders conference is by invitation only and consists of an elite group of medical researchers and clinicians. The third journal, *Eating Disorders*, defines itself as a comprehensive multidisciplinary journal addressing the treatment and education of eating disorders. All three of the journals utilize accepted double-blind, peer review processes and have a distinguished board of established eating disorders researchers and clinicians. Two of these journals were found to have citation indexes. The *International Journal of Eating Disorders* had an impact factor of 2.392 and 5646 total citations; the *European Eating Disorders Review* had an impact factor of 0.98 and 590 total citations. The journal *Eating Disorders* was not included in the citation index and accordingly no impact factor or total citations could be established.

In order to establish current understandings of the way anorexia nervosa is being explained and constructed, all the articles written during the year 2009 that addressed anorexia nervosa and were published in the three central eating disorders journals presented above were carefully read. The corpus was constructed by electronically searching for the term anorexia nervosa in the title, abstract and body of all articles from the three journals. This search produced a corpus of 101 articles. Using the Malson's (1998) taxonomy of categories as a guideline, each of the articles was read and evaluated for consideration within one of the proposed categories. The aims of this reading were to evaluate whether Malson's (1998) review of possible ways of explaining anorexia nervosa was still valid, if any new categories of explanation needed to be constructed and to explore the frequency of usage of the different categories.

6.4.2 Results

Table 6.1 presents a summary of the frequency of occurrence for each of the categories in Malson's (1998) taxonomy and by journal. As can be seen in Table 6.1, there are differences in the frequency of the categories across the different journals. Importantly, the most cited of these journals and the journal most closely linked to the process of revising the diagnostic criteria of the DSM – the *International Journal of Eating Disorders* – is characterized by an emphasis on the description of anorexia nervosa as a form of natural disease. This is very different from the other journals and reveals a particular orientation in this journal to explore anorexia nervosa as a physical-biological disorder. It is also noteworthy that the only paper which explored the genetic predisposition for anorexia nervosa was also published in this journal. The significance of these findings is that this

journal which is most closely linked with the most influential researchers of eating disorders desires to follow the discursive guidelines of the medicalization of anorexia nervosa. It should be noted that this is an a'priori orientation of the actual research they are conducting.

Table 6.1 Frequency of Occurrence of Category of Explanation of Anorexia by Journal

Category	***Eating Disorders* Frequency**	***International Journal of Eating Disorders* Frequency**	***European Eating Disorders Review* Frequency**	**Total**	**Percentage of Total**
Natural Disease	2	13	3	18	17.8%
Genetic Predisposition	-	1	-	1	0.9%
Affective Disorder	2	1		3	2.9%
Cognitive Dysfunction	2	6	2	10	9.9%
Body Image Distortion	3	2	7	12	11.9%
Familial Pathology	2	7	6	15	14.85%
Psychodynamic Disturbance	4	2	6	12	11.9%
Restrained Eating	1	3	1	5	4.9%
Socio-Cultural Context	5	7	10	23	22.7%
Gender	-	1	1	2	1.9%

Overall, across all the journals the largest category (22.7%) utilized in the description of anorexia nervosa in 2009 consisted of a consideration of the socio-cultural context. This is a very interesting result that reveals the significance of the relationship between socio-cultural context and the phenomena of self-starving women. This finding is particularly remarkable in relation to the orientation of the *International Journal of Eating Disorders* towards the medicalization of anorexia nervosa and suggests a difference between orientations to the understanding of anorexia between different researchers in psychiatry. However, it should be noted that socio-cultural direction of explanation consisted mainly of two types of social-cultural consideration: the role of a variety of support groups (some on-line) and communities in reinforcing or mitigating the effects of anorexia nervosa and consideration of the phenomenon of anorexia nervosa in different countries and communities using a demographic perspective. In other words, while this category was the most frequently referenced, it did not involve the deeper critical analysis of the workings of society (and in particular the social construction of gender) as a cause of anorexia nervosa. The papers found within this category had a more instrumental and pragmatic approach to social cultural

factors in anorexia nervosa as a demographic issue and not a critical approach to the analysis of society. But, this is still an important finding in that there seems to be some acknowledgement of the social context within which anorexia nervosa develops and this stands in stark opposition to the concept of the medicalization of anorexia nervosa propagated in the *International Journal of Eating Disorders*.

A consideration of gender was found only in two specific papers. This is a striking result since the data on frequency of anorexia nervosa is heavily biased towards women with a ratio of 11 females for each 1 male sufferer (Gowers, *et al.*, 2010). Accordingly, the lack of research exploring gender is really quite bizarre and suggests that broader disciplinary discursive guidelines create an aversion to this research agenda although the actual data of frequency of occurrence would suggest that gender is a major issue to be explicated and analysed. In the current corpus, gender when considered was addressed from a statistical perspective and not through critical analysis of the social construction and psychological and social ramifications of gender. The statistical data that was presented such as Steigel-Moore *et al.* (2009) shows that women are statistically more likely than men to engage in behaviours characteristic of anorexia nervosa such as vomiting, fasting, and checking their bodies which suggests a broader gendered aspect to this phenomena which was also present in the limited number of paper dealing with restrained eating. But this was not followed up or analysed for its critical components. Thus, as with the category of socio-cultural understandings of anorexia nervosa there is a lack of critical understanding and interaction with social phenomena such as gender.

Cognitive dysfunction and body image distortion together made up 21.8% of all papers mainly addressing the role and usage of cognitive behaviour approaches to therapy in the treatment of anorexia nervosa. The relatively large proportion of papers with this direction in 2009 reinforces the decontextualized understanding of anorexia nervosa that looks at the phenomena of self starving women without a critical understanding of socio-cultural context and as part of the individual's cognitive system. This direction is also based on the discursive guidelines of psychiatry that desires measurable outcomes for treatment and diagnosis both of which can be provided by considering cognitive dysfunction and body image. Thus within the discourse of psychiatry there is a preference for studies that can measure anorexia nervosa. Both of these categories propagate the idea that women with anorexia are cognitively deficient.

One interesting aspect of the review of the papers in these categories was the usage of yoga in treating anorexia nervosa based on the idea that this would aid anorexic patients to

evaluate more accurately the size and shape of their physical bodies. The discursive guidelines of psychiatry and its way of interacting with other disciplines become very clear when yoga is limited to a tool for helping women with anorexia to cognitively understand their body size and shape without valuing the broader holistic aspects of yoga. Thus the psychiatric discourse of measurement, illness as situated in an individual and instrumentalism override all other considerations.

Within the category of familial pathology, the majority of papers dealt with the relationship between parental problems (without an explicit singling out of mother's blame) and the onset of anorexia. This is interesting in that it seems that within the psychiatric literature in 2009 there is a general movement away from explicitly blaming of parents or mothers. This can be seen as a response to broader societal desires for political correctness in discourse. This does not mean that blame does not actually exist hidden within the deeper meanings of each explanation. But it is not explicitly stated.

An additional discursive aspect is that as with previous categories the understandings of family structure, function and behaviours is disconnected from the social and cultural discourse in which families exist and are constituted. In this sense, while a broader frame that of the family is provided for the development of anorexia nervosa the family as an agent of a social cultural context is not actually acknowledged. For example, hierarchal relationships in the family such as the subordination of women and the ways these are constructed in society and reproduced in many families are not addressed. As such this category within psychiatric discourse once again distances critical socio-cultural understandings.

The category of psychodynamic disturbance dealt mainly with personality disorders as a factor in the development and treatment of anorexia nervosa. In one sense the presence of this category references a large literature that historically has defined anorexia nervosa in psychodynamic terms. It should be noted that this way of understanding anorexia nervosa, once the predominant approach, has know been reduced to 11.9% of the papers in 2009. Broadly, this shows a direction which involves moving away from psychodynamic explanations in the psychiatric literature and is part of the psychiatric discourse that prefers Kraepelin to Freud.

6.4.3 Discussion of Findings: Anorexia Nervosa and Psychiatric Discourse in 2009

The aims of the first study in this chapter were to update Malson's (1998) category system, to explore the ways in which anorexia nervosa is constructed and to consider the role of disciplinary discourse on this construction. Broadly, all the papers read were within the framework of Malson's (1998) taxonomy and no completely news ways of explaining

anorexia nervosa were proposed. Accordingly Malson's (1998) taxonomy can still be considered a useful tool for exploring the construction of anorexia nervosa in the 21st century and this taxonomy captures a range of options for explaining anorexia nervosa.

A more interesting set of results relates to the role of disciplinary discourse in directing research activity and constructing the concept of anorexia nervosa. The discursive guidelines of the field of psychiatry seem to be deeply influenced by the forces outlined in relation to the theoretical and historical analysis of the power of psychiatry outlined in Chapter Five. Specifically the role of Neo-Kraepelinian assumptions concerning psychiatry would seem to have influenced the development of a series of research projects. The researchers most closely associated with the redrafting of the DSM and the *International Journal of Eating Disorders* have continued a process of exploring anorexia nervosa as a genetic and biological phenomenon. This process of medicalization finds its roots within the ideas of psychiatry as a field of medicine and as such biological measures are preferred.

A related aspect of Neo-Kraepelinian thinking deals with the desire for psychiatric research to use scientific measures. As a disciplinary guideline there is a preference for explicit, measurable symptoms. This guideline for explicit symptoms gives preference to studies and approaches that can actually provide this form of data. As seen in the review of the corpus above, a fifth (21.8%) of all the studies related to cognitive behaviour therapy and explanations of cognitive dysfunction and body image distortion. Both the categories of cognitive dysfunction and body image distortion are tied to cognitive behaviour therapy and allow symptoms to be expressed in explicit quantifiable forms.

One interesting and seemingly contradictory finding deals with the high frequency of papers that explore socio-cultural understandings of anorexia. One would have thought that against the backdrop of a Neo-Kraepelinian ideology, socio-cultural studies would be ignored. It is even more surprising since a socio-cultural approach would seem to counter both the ideas that anorexia nervosa is a medical-biological condition and that it is a cognitive condition situated in the psyche of the individual. As reviewed above, the type of socio-cultural study is more demographic than critical and basically sets out communities within which anorexia nervosa is becoming prevalent. Thus it is a very specific type of socio-cultural study. But, it should be noted that the presence of these studies from this orientation suggests that there is some recognition of the role of social context in developing, maintaining and supporting anorexia nervosa.

There is however no recognition or attempt to critically interact with socio-cultural forces. Broadly across the whole corpus there is lack of any critical understanding of anorexia

nervosa. Most striking on this level is the nearly complete avoidance of studies of gender. This is indeed quite difficult to explain from the perspective of the discipline of psychiatry. Surely the statistics on the frequency of anorexia nervosa among women would direct a decision making process based on the empirical evidence that gender is an important category to consider. Thus it seems that the field of psychiatry is ignoring one of its own discursive principles that it is a scientific field directed by empirical evidence.

One way to explain this seeming contradiction is to consider some additional findings from the current analysis. In addition to an avoidance of gender there is also an attempt to avoid the language of blame and in-depth socio-cultural analysis. Thus we have a field which prefers biological and explicit evidence situated in the individual but also does not wish to create a narrative of blame or really explore the socio-cultural context. Statistical data reveals gender as a factor but a real consideration of this would require close consideration of socio-cultural forces and how society constructs women. As discussed in the historical review of the medical concept of anorexia nervosa, in previous manifestations a biological connection to the female body was made and anorexia nervosa was described in terms of the physiological and psychological failings of women. This way of constructing women is not politically correct and would create a narrative of blame. Thus the dilemma is to either follow a path which would clearly be seen as misogynist (but in accordance with disciplinary guidelines) or to invalidate the basic guidelines of disciplinary discourse. Accordingly, very few studies of gender were conducted and this most obvious of variables in anorexia nervosa is basically ignored.

It is worth noting that the concept of blame has undergone a change within the psychiatric literature. As discussed above explicit blame of mothers, patients with anorexia and families is currently being avoided. However, when the underpinning explanation of anorexia is situated in the individual, then a degree of blame is still being assigned to that individual. In particular, cognitive approaches suggest that there is something wrong and distorted in the psyche of patients with anorexia. Thus, while explicit statements of blame have been removed from the discourse of psychiatry, on a deeper level of analysis these are still present. This process of purging explicit blame of women is characteristic of discourse in the 21st century as analysed by the feminist critical discourse analyst Michele Lazar (2005).

Another historical trend found in this data and an extension of Neo-Kraepelinian ideas is the movement away from psychodynamic explanations of anorexia nervosa. While these still exist they were only 11.9% of the collected studies. The movement is clearly towards biological, cognitive and pragmatic socio-cultural explanations and is based on the broader

discursive guidelines of psychiatry that require explicit evidence, a rhetoric of science and avoidance of direct accusatory narratives. It is a position that situates mental illness in the individual and limits the role of socio-cultural context to pragmatic factors. The irony of this position is that the statistical data within psychiatry would suggest that anorexia nervosa is a gendered, socio-cultural phenomenon and as such would benefit from an approach that explored the role of gender and conducted critical studies of the social and cultural contexts of self-starving women.

6.5 The Construction of Anorexia Nervosa in the Revision of DSM IV

The aim of this section is to present a second study of the construction of anorexia nervosa within the psychiatric literature. The corpus to be considered for this study consists of the definition of anorexia nervosa in the existing DSM IV and a consideration of articles outlining the revisions that are being considered for the next version of the DSM. Chapter Five of this dissertation analysed the central importance of the DSM IV in directing and enforcing specific ways of understanding anorexia nervosa. As discussed there, the DSM is a textual mechanism for controlling the thinking and actions of researchers, psychiatrists and other clinical practitioners. An analysis of the DSM IV (the latest published version) can provide an insight into the way anorexia nervosa is being defined. However, while this strategy is a starting point, it is insufficient as currently the DSM V is being prepared for publication in 2013. So there was also a need to analyse the changes being suggested for the new version. As a result of the centrality of the DSM, the analysis proposed in this section can reveal the most influential choices of how to define anorexia nervosa within the psychiatric literature. The decisions around the definition of anorexia nervosa within the different versions of the DSM are a classic example of the micro-physics of power in which certain statements are chosen for inclusion or exclusion within a discourse. A close consideration of this process should reveal the workings of psychiatric discourse in relation to the understanding of anorexia nervosa at this juncture.

6.5.1 Methodological Issues

The process of revising the DSM includes a series of written reviews of published research including conclusions that are presented to other psychiatrists for consideration. These reviews were published in the *International Journal of Eating Disorders* which, as specified above, is the official publication of the Academy for Eating Disorders under a special section dealing with the revision of the DSM criteria for the diagnosis of eating disorders. Accordingly, the DSM IV and these review articles provide insight into the way psychiatry as a field defines anorexia nervosa. The specific materials analyzed for their

contribution to the way anorexia nervosa is constructed in the field of psychiatry are as follows:

1. *The DSM IV – diagnostic criteria for anorexia nervosa*:

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (Fourth ed.). Washington DC: American Psychiatric Association.

2. *Special Section Review Articles – Eating Disorders in DSM V: Reviews of Existing Literature*:

Attia, E., & Roberto, C. A. (2009). Should amenorrhea be a diagnostic criterion for anorexia nervosa? *International Journal of Eating Disorders , 42* (7), 581-589.

Becker, A. E., Eddy, K. T., & Perloe, A. (2009). Clarifying criteria for cognitive signs and symptoms for eating disorders in DSM-V. *International Journal of Eating Disorders , 42* (7), 611-619.

Becker, A., Thomas, J. J., & Pike, K. M. (2009). Should non-fat-phobic anorexia nervosa be included in DSM-V? *International Journal of Eating Disorders , 42* (7), 620-635.

Peat, C., Mitchell, J. E., Hoek, H. W., & Wonderlich, S. A. (2009). Validity and utility in subtyping anorexia nervosa. *International Journal of Eating Disorders , 42* (7), 590-594.

Walsh, T. (2009). Eating disorders in DSM-V: Review of existing literature (Part 1). *International Journal of Eating Disorders , 42* (7), 579-580.

Walsh, T., & Sysko, R. (2009). Broad categories for the diagnosis of eating disorders (BCD-ED): An alternative system of classification. *International Journal of Eating Disorders , 42*, NA.

3. *Position Paper – Academy for Eating Disorders:*

Klump, K., Bulik, C. M., Kaye, W. H., Janet, T., & Tyson, E. (2009). Academy for Eating Disorders position paper: Eating disorders are serious mental illnesses. *International Journal of Eating Disorders , 42* (2), 97-103.

This set of articles consists of the complete collection of reviews addressing anorexia nervosa. These articles in conjunction with the existing DSM-IV are written by the central psychiatric clinicians and researchers involved in the revision of the diagnostic category of anorexia nervosa within the new, not yet published, DSM-V and provide the central authoritative description and understanding of this phenomenon by this field. Accordingly, for the purposes of this dissertation an analysis of this corpus allows a discussion of the way the field of psychiatry is constructing anorexia nervosa and the ramifications of this on the construction of women.

6.5.2 The Diagnostic Construction of Anorexia Nervosa – DSM-IV

The DSM-IV positions anorexia nervosa as a separate category of diagnosis under the broader heading of "Eating Disorders". The structure of information for clinical diagnosis in the DSM-IV consists of first providing what are termed "Diagnostic Features" – a specification of the diagnostic criteria of the disorder being addressed. These are followed by a specification of "subtypes" and their indicators. These two main sections are followed by sections entitled "Associated Features and Disorders", "Specific Culture, Age, and Gender Features", "Prevalence", "Course", "Familial Pattern" and "Differential Diagnosis". The clinical definition of anorexia nervosa starts with the following set of statements:

> "The essential features of Anorexia Nervosa are that the individual refuses to maintain a normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body. In addition, postmenarcheal females with this disorder are amenorrheic" (American Psychiatric Association, 1994, p. 539).

In this initial quote several underpinning disciplinary discursive guidelines are apparent. First, the disorder is situated in an individual with full agency. According to this definition, this individual is defiant (note the usage of the word "refuses") in her willingness to maintain body weight. Second, the clinical indicators of this disorder are defined in relation to explicit behavioural symptoms. The anorexic is defined by her unwillingess to maintain "normal" body weight, her fear of weight gain and distorted perception. Third, there is an attempt to address explicit physical criteria by adding amenorrhea for females. Thus, this initial definition constructs 4 core criteria for defining anorexia nervosa: A. Refusal to maintain weight; B. Intense fear of gaining weight; C. Disturbance in the experience of body weight or shape; D. Amenorrhea.

In the continuation of this section, each of these criteria is further explicated. In relation to body weight, the DSM-IV delineates guidelines for specifying anorexic body weight. These are 85% of normal body weight as defined by the Metropolitan Life Insurance tables or a body mass index (BMI) of 17.5 kg/m.^{2}. However, the clinician is warned to consider the individuals "body build and weight history" in using this criteria, thus allowing a degree of physician interpretation. The weight criteria are further explicated by a consideration of the behaviours which result in weight loss. According to the DSM-IV these include reduction in total food intake, self induced vomiting and/or the use of laxatives and diuretics, and excessive exercise.

In relation to fear of weight gain, the manual specifies that fear of weight gain increases when weight loss actually continues to decrease. In relation to body and weight distortion the manual specifies that some patients with anorexia feel "globally overweight" while others are concerned about specific parts of their body in particular abdomen, buttocks and thighs. Certain behaviours are associated with body/weight distortion including excessive weighing, body part measurement and persistent mirror checking. Furthermore, the DSM-IV specifies that the "self esteem of individuals with anorexia nervosa is highly dependent on their body shape and weight. Weight loss is viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control" (American Psychiatric Association, 1994, p. 540). Finally in relation to amenorrhea, the manual specifies that this condition is the result of weight loss.

In the next section the manual specifies two subtypes of anorexia nervosa: Restricting type and Binge-Eating/Purging type. The difference between these two types relates to the way they achieve weight loss. According to the DSM-IV, the restricting type of anorexic achieves weight loss through dieting, fasting and excessive exercise. The Binge-Eating/Purging type of anorexic involves periods of binge eating followed by self-induced vomiting and the misuse of laxatives and this is the way weight loss is achieved. In the sections that follow, the manual specifies that anorexia is associated with depression and obsessive compulsive behaviours. The manual also specifies what it calls "other features" associated with anorexia nervosa which include: "concerns about eating in public, feelings of ineffectiveness, a strong need to control one's environment, inflexible thinking, limited social spontaneity, and overly restrained initiative and emotional expression" (American Psychiatric Association, 1994, p. 541). The manual specifically states that there are no laboratory abnormalities for anorexia nervosa but the presence of self starvation causes physical signs that can be detected.

Under the heading of cultural, age and gender features of anorexia nervosa, the manual specifies that anorexia nervosa is more prevalent in "industrialized societies" where "being considered attractive is linked to being thin" (American Psychiatric Association, 1994, p. 542). The manual further states that immigration into an industrialized culture increases the frequency of anorexia nervosa as "thin-body ideals are assimilated" and accepts the idea that "Cultural factors may also influence the manifestation of the disorder" (p. 543). The manual states that 90% of the cases of anorexia nervosa are in females and that the onset of the illness is between the ages of 13-18, early adolescence.

In accordance with the Neo-Kraepelinian criteria of being able to directly clearly differentiate one disorder from another, the final section of the criteria for diagnosing anorexia nervosa consists of what is termed 'Differential Diagnosis". In this section clinicians are directed towards other mental and medical disorders in which weight loss occurs such as gastrointestinal disease, brain tumours or AIDS but the differential feature of anorexia nervosa is the lack of a distorted body image or a fear of weight gain. In relation to the mental disorders of major depressive disorder and schizophrenia the same differential features are specified. Other disorders such as social phobia, obsessive compulsive disorder and body dismorphic disorder may involve a diagnosis in addition to anorexia nervosa.

6.5.3 Summary of Analysis of the Construction of Anorexia Nervosa in the DSM-IV

In considering the whole section of the DSM-IV, the construction of anorexia is clearly directed by disciplinary, discursive guidelines. The physical and behavioural is foregrounded and the cultural and social backgrounded. It is interesting that there is ample evidence presented in this document to really foreground the gendered, socio-cultural aspects of anorexia nervosa, and the document clearly specifies that there are no pre-existing physiological conditions that can be identified through laboratory tests of this disorder. For example, the manual clearly specifies that greater prevalence of anorexia in industrialized societies and that the assimilation of the thinness ideal is a cause of anorexia. Furthermore, the manual specified the gender difference that this is predominantly a disorder that is suffered by women and is at the onset of adolescence. But there is no attempt to critically explore gender such as an analysis of presented evidence that connects the features of low self esteem and feelings of ineffectiveness with gender issues (although there is data that could explicate such a relationship - see Hoskins, 2002 and Malson, 1998). The a-priori guideline that mental disorders are physical and situated in the individual directs the priorities set for the way anorexia is defined here. The absence of a deeper cultural analysis concerning the relationship between gender, cultural influences and the presence of anorexia is glaringly absent from this definition and results from the limitations of this specific disciplinary way of constructing knowledge.

One of the major outcomes of the DSM IV was the specification of four core criteria that are widely used within and beyond the discipline of psychiatry to define anorexia nervosa. Arguable these criteria are the single most influential definition of anorexia that is currently available (and the most widely propagated and disseminated). These four criteria can be seen as the result of two different types of disciplinary discursive force: the Neo-Kraepelinian preference for explicit, biologically-based symptoms and the prior disciplinary

history of constructing anorexia nervosa. All four criteria lend themselves to observation by the clinician. *Disturbance in the experience of body weight or shape* is clearly related to Malson's (1998) category of body image distortion and addresses the research findings within this literature. *Amenorrhea* identifies anorexia nervosa as a gendered phenomenon; even though the emphasis is on the physical aspects of being a woman and not the socio-cultural aspects. *Intense fear of gaining weight* can be seen as referencing the literature on cognitive dysfunction relating to the presence of, what has been termed, irrational thoughts. The presence of the concept of fear within this criteria can also be seen as acknowledgement of earlier psychodynamic descriptions of anorexia but without the presence of the narrative and associated explanations of anorexia that appear within that literature. The *refusal to maintain weight* results primarily from the desire to have a clear measureable characteristic of anorexia nervosa – the issue of weight. But this is overlaid with the additional behavioural aspects of actions that lead to weight loss. Part of this criterion is the aspect of situating anorexia nervosa in the individual patients and seeing this patient as defiant. This description of the patient with anorexia is reminiscent of far earlier descriptions (such as Gull) in which the wilfulness of the patient needed to be overcome. As such the concept of refusal raises the power relationships between the girl with anorexia and her surroundings.

Overall, these four criteria create a very particular description of anorexia as a female disorder (the criteria of amenorrhea) that involves a cognitive distortion (irrational thoughts and body image distortion) and is expressed through low weight and the behaviours of losing weight (refusal to maintain weight). The female patient with anorexia is still seen as suffering from irrational thoughts, being cognitively impaired and as obstinate and personally wilful. While the language of the DSM IV is distant and authoritative, underpinning the actual core descriptors of anorexia nervosa is a definition that is reminiscent of the ways women have been described in the patriarchal, history of medical discourse (see the beginning of this chapter for a review).

On a functional level, it is interesting to note the degree to which the actual language of the diagnostic formulations in the DSM-IV is dependent on individual judgment. This is basically a linguistic problem but addresses the main justification of the existence of the DSM. As a tool that is designed to increase reliability, the presence of interpretable criteria is a real problem. The issue can clearly be seen in the core criteria of anorexia nervosa. For example, there are many ways in which the term "refusal to maintain normal weight" can be understood. When exactly does the restriction of food intake constitute a refusal? If a meal is missed is that a refusal? If one only eats a limited amount of food is that a refusal? The same

linguistic problem also exists for the emotional and cognitive factors. What is the dividing line between fear of fat and intense fear of fat? Or the dividing line for a disturbance in body shape of weight? As discussed above, even the definition of normal body weight is open to interpretation as the clinician needs to take into account body shape and size.

This problem of the interpretation of the relative language used in the DSM is further exasperated by the usage of the diagnostic interview. According to the DSM-IV the anorexic patient is an unreliable source of information. The DSM-IV describes anorexic patients as "unreliable historians" and suggests that information concerning the patient be collected from what is termed "outside sources". In other words, everything said in the diagnostic interview needs to be interpreted and may be based on what legal courts would consider to be indirect evidence (hearsay). This situation undercuts the supposed reliability and objectivity of the diagnosis and situates this process as interpretative. This approach also negates the reliability of the anorexic patient and constructs her in a subordinate role. Furthermore this way of constructing the diagnostic interaction positions the physician-patient relationship on the basis of mistrust and as a power struggle in which the patient's voice is consistently qualified and judged. Ironically, it can be extrapolated from this position that the very construction of the anorexic patient as untrustworthy within a power relationship with the psychiatrist reinforces the need for the anorexic patient to respond with mistrust towards the psychiatrist and not provide the information the psychiatrist wants. This interactional aspect of the diagnostic interview influences the way the diagnostic interview is conducted and moves it still further away from the objective collection of data that it is assumed to be.

6.5.4 Changes to the Diagnostic Criteria of Anorexia Nervosa in the DSM-V

The process of revising the DSM-IV is currently underway. The literacy aspect of this process involves the publication of a series of review and overview articles addressing what are considered the major issues of concern in the current DSM-IV in relation to anorexia nervosa. A review of the corpus of articles specified above in section 6.5.1 reveals very serious concerns over the quality, validity and applicability of the definitions currently used for diagnosing anorexia nervosa. The concerns are of two core types: 1) One group of articles addresses specific decisions made in the diagnostic categories of the DSM-IV; 2) The second group questions the viability of the diagnostic scheme itself.

In the first group, questions have been raised concerning the inclusion of the criterion of amenorrhea as a compulsory category (Attia & Roberto, 2009). As presented by Attia and Reberto (2009) the arguments for the inclusion of amenorrhea as a diagnostic category are that "it is clear and objective" and may help to "avoid misdiagnosis of AN by providing a

marker of abnormal physiology that helps distinguish constitutionally thin women who are underweight by menstruating from women with AN" (p. 581). Attia and Roberto's (2009) arguments against inclusion are that many "individuals fail to meet the amenorrhea criterion despite exhibiting all other criteria of AN, thereby placing them in the Eating Disordered Not Otherwise Specified (EDNOS) category" (p. 581) and that this criterion is "problematic because it cannot be applied to males, to post-menopausal women or to women using hormone replacements such as oral contraceptives" (p. 582). Accordingly, the main objection here is that amenorrhea is too reductive and excludes patients who are not young women (still the predominant statistical category of anorexic patients). Based on the Neo-Kraepelinian guidelines that diagnostic categories should be able to clearly distinguish one disorder from another, the conclusion of this review paper suggests that amenorrhea be eliminated as a diagnostic category in itself and rather situated as an "associated" medical condition.

From the perspective of this dissertation, this recommendation raises two interesting issues: first of all the issue of gender is addressed with the attempt to reduce the explicit gendered orientation of anorexia nervosa (in the direction of making it supposedly more gender neutral); second, the problem of the quality of the existing criteria for diagnosing anorexia nervosa is questioned. In relation to the issue of gender this suggestion that amenorrhea be removed as a criteria may hide the gendered nature of anorexia nervosa and thus pushing the definition and treatment of anorexia further into the medical camp at the price of addressing discursive, cultural factors. This is an extension of the process already observed in the study of corpus of journal articles in 2009 – the avoidance of studying gender as a variable in anorexia nervosa.

This second issue which involves recognition of the problems with actually conducting a diagnosis manifests itself as the over-usage of the category of Eating Disorder Not Otherwise Specified (EDNOS). Essentially, as a result of the failure of the categories of definition of anorexia (and by inference perhaps the whole Neo-Kraepelinian diagnostic scheme) a 'catch-all' category of eating disorders (EDNOS) became the most prevalent diagnosed category of eating disorders (Fairburn, Cooper, Bohn, O'Connor, Doll, and Palmer, 2007). It should be noted that the presence of a catch-all category such as EDNOS brings into question both the validity and reliability of the whole eating disorders diagnostic system as defined in the DSM IV. This suggests that the existing criteria do not actually differentiate well between the different eating disorders categories on the basis of how they are currently defined. This is a problem that has been noted by other eating disorders

researchers such as Fairburn, Cooper, Bohn, O'Connor, Doll, and Palmer (2007) in their analysis of the problems in the EDNOS category.

The validity and reliability of the diagnostic scheme is questioned also in relation to the value of the two sub-types - Anorexia Nervosa Restrictive Type and Anorexia Nervosa Binge-Eating/Purging Type (Peat, Mitchell, Hoek, & Wonderlich, 2009). Of central importance to this published review is the question of the predictive validity of this sub-typing scheme. In other words, does research conducted based on the definition of these two groups (Anorexia Nervosa Restrictive Type and Anorexia Nervosa Binge-Eating/Purging Type) produce evidence that systematically shows differences between them. The conclusion of this review is that the current sub-group categorization does not have predictive validity and as such is problematic. In other words, the research that was reviewed found that the symptoms associated with each group did not clearly differentiate them into two different groups.

As discussed above the expression of diagnostic criteria in language creates a situation in which there is extensive interpretation that is conducted by the diagnosing clinician. Accordingly it is very interesting to note the specific reasons for the difficulty in differentiating between sub-groups specified by these researchers. As analysed by Peat, Mitchell, Hoek and Wonderlich (2009) one of the central problems of the current scheme is the DSM-IV definition of "regularly engaged" in binge-eating and purging behaviour. As presented by Peat, Mitchell, Hoek and Wonderlich (2009) "clinicians are free to interpret this criterion as they wish, and there are no data to suggest how this is usually done in practice" (p. 593). Furthermore, they state that the definition of binge eating is problematic as "many patients with AN eat relatively modest amounts of food when they indicate they had an eating binge" (p. 593).

An additional interesting aspect of this review is the evidence presented concerning the phenomena of 'crossing-over' from one category of anorexia to another. The writers of this article state that there is "significant crossover" between "diagnostic subgroups of AN, from AN to BN and some crossover from BN to AN as well" (p. 592). This problem of crossing over from Bulimia Nervosa (BN) to Anorexia Nervosa (AN) or vice versa means that these are not the stable, medical disorders and that the criteria do not clearly differentiate between conditions. The presence of this empirical evidence on the lack of reliability of the criteria themselves should bring into question the whole of the DSM's Neo-Kraepelinian approach. This review clearly designates the linguistic, interpretive nature of the criteria of the current DSM definitions of anorexia nervosa and presents evidence of their inability to

define discrete aspects of this phenomenon. Furthermore, the data that patients cross over from one type of eating disorder to another would suggest that anorexia nervosa is a response to socio-cultural context rather than a biological entity.

The linguistic problems of the DSM are directly addressed in a review of the cognitive aspects of existing criteria for the diagnosis of anorexia nervosa. In an explicit recognition of the problematicity of language, Becker, Eddy and Perloe (2009) state that there is a need for "clarifying the phrasing and accompanying text for the DSM-IV AN criteria A-C" in order to "enhance their valid and reliable application in clinical settings" (p. 612). These researchers raise several specific concerns with the existing language of the DSM-IV. A central target of complaint concerns the usage of the word "refusal" in the core diagnostic criteria of anorexia nervosa – "refusal to maintain body weight". Becker, Eddy and Perloe (2009) argue that:

> "the term "refusal" connotes behavior that is wilful and even obstreperous. In doing so, this word's usage presupposes capacity and agency to formulate an intention (not maintaining weight), choose a course of action (to undermine weight gain), and to express this intention (endorse a refusal). A universal assumption of this capacity and motivation among individuals with AN is unfounded. Moreover, the frame of "refusal" potentially lays the groundwork for an embattled relationship between clinician and patient" (p. 612).

In this quote, the authors explicate the semantic and pragmatic ramifications of the term refusal and situate this as problematic because it constructs an adversary relationship based on individual agency. Even though the justification for this discussion is the clarification of diagnostic criteria, this is explicit recognition of the problematic way in which anorexic patients have been constructed in the DSM-IV and the core assumption of individual agency. In particular it is revealing that these researchers recognize that the inclusion of the concept of "refusal" is not empirically founded. As I have analysed above, the existing definition of anorexia within the DSM IV contains language and concepts drawn from the history of disciplinary discourse and contains problematic patriarchal overtones.

In further explicating their position, the authors of this paper, discuss two related problems: 1) the cultural relativity of the cognitive dimensions of the diagnostic criteria of anorexia nervosa; & 2) patient capacity and willingness to explicitly acknowledge eating issues. As argued by these authors, the terminology of the existing diagnostic criteria which state that anorexia nervosa as defined by "undue influence of body weight or shape on self evaluation" requires, for proper diagnostic assessment, reference to the local cultural norms

concerning body weight and shape. Specifically they state that these patient perceptions "reflect culturally embedded core values and notions about self-agency that influence the perceived feasibility and social desirability of managing weight" (Becker, Eddy and Perloe, 2009, p. 612). Thus, these researchers essentially criticize the DSM IV for a lack of understanding concerning the cultural contextualization of the anorexic patient. Furthermore, they recognize that the "pursuit of thinness" in the Western world involves the connection between identity, self and body and the belief that "individuals can exert control over their shape or weight" (p. 612). Further they acknowledge that the expression of distress by patients changes in relation to the cultural context. These researchers recognize the centrality of the social and cultural context of the development of anorexia nervosa and suggest that clinicians need to be directly aware of this conceptual frame in order to be able to diagnose anorexia nervosa.

These authors also problematize the anorexic patients' self-positioning during the diagnostic interview. According to these authors, anorexic patients may have different reasons for not acknowledging or expressing any symptoms they may have. Anorexic patients may not wish to disclose their symptoms as they have an "investment in maintaining their symptoms" or may be trying to avoid the "stigma" attached to acknowledging anorexia nervosa (p. 614). As constructed here, anorexia allows "emotional avoidance, increased sense of safety, and secondary gains of communicating distress and engaging care" (Becker, Eddy and Perloe, 2009, p. 614). In addition, anorexics may "derive a sense of personal accomplishment" from their symptoms (p. 614). In other words, there is acknowledgement here for the phenomenology of the anorexia and the problem of simplistic assumptions about the patient-clinician relationship. This recognition offers a direct, culturally-based criticism of the existing approach and language of the DSM IV and moves beyond the presentation of anorexia nervosa as a medical condition in which patients' honestly and directly answer clinical questions.

While Becker, Eddy and Perloe (2009) explicitly recognize and discuss the problem of language usage in the DSM IV and the cultural contextualization of anorexia and its symptoms, their solution to this situation involves a return to the strict disciplinary guidelines of the Neo-Kraepelinian approach to psychiatric diagnosis and to an extent a reversal of their own position. Becker, Eddy and Perloe (2009) suggest that the word "refusal" could be replaced with the words "resistance" or "difficulty" and that the patient's weight should be considered without a consideration of the reasons leading to weight loss. In other words, they suggest that more 'precise' language choice and a focus on explicit empirical evidence

(weight) will make the DSM V function better as a diagnostic tool. The solution posed suggests that by using "better" more "accurate" language and by using the objective measure of weight the problems of the interpreting the symptoms of anorexia nervosa will decrease.

This is an interesting shift especially considering the degree to which this particular article recognizes the cultural and social contextualization of the cognitive manifestations of anorexia nervosa and, perhaps, demonstrates the strength of the disciplinary guidelines that are in play in the revision of the DSM-IV that marginalize culturally sensitive discursive approaches. However, it should be noted that this particular article does end with a recommendation that the DSM be augmented with text that emphasizes "the fluid and culture-specific nature of social norms anchoring weight and body shape concerns" (Becker, Eddy and Perloe, 2009, p. 618). This final statement does not undo or threaten the existing hierarchy of psychiatric disciplinary discourse which desires explicit symptoms and biological evidence. In fact, it demonstrates exactly the way this discourse works. While the review article raises very serious concerns about language and cultural context and shows the ramifications of this on the existing criteria of the DSM IV, in the end this analysis and its adjacent empirical evidence is downgraded to the position of augmenting text and not as a starting point for a serious re-evaluation of the approach used in the DSM V.

In another review article, Anne Becker with a different group of researchers explores the issue of the cultural specificity of the current diagnostic criteria of anorexia nervosa in the DSM. Becker, Thomas and Pike's (2009) review of whether the category of anorexia nervosa should be widened so as to include non-fat phobic anorexia nervosa is an attempt to change the underlying scheme of the existing diagnostic criteria of the DSM and as such belongs to the second group of review articles which questions the viability of the diagnostic scheme itself. The issue is in some ways a simple one: researchers, in a series of non-Western countries, have reported on a form of anorexia nervosa that does not include a phobia concerning being fat. Accordingly, these patients have all the symptoms of anorexia but without the diagnostic criteria of fear of gaining weight that is clearly expressed in the DSM-IV. This makes their diagnosis problematic and raises the issues of forms of anorexia that are different in a variety of socio-cultural settings. Some of the variation across cultures exists in relation to the desire for thinness with girls from Western countries expressing statistically different degrees of this desire than girls from non-Western countries.

Based on these findings several options for changes to the current diagnostic criteria were proposed. There is the option of changing the language of the current DSM from "afraid of gaining weight" to alternative constructions such as "phenomenologically pluralistic

conceptualization of self-imposed emaciation", "ego-syntonic weight loss", or "overinvestment in eating restraint" (Becker, Thomas & Pike, 2009, p. 630). This would eliminate fat-phobia as a core criterion of anorexia nervosa and as such allow more flexibility in incorporating cultural difference in the manifestation of anorexia nervosa. A different set of options is to add non-fat phobic anorexia nervosa as a subtype of anorexia; to include it within the category of Eating Disorder Not Otherwise Specified; or to continue to ignore this phenomenon and not include it at all with the definitions of anorexia nervosa.

This discussion of the phenomenon self starving women who in non-Western countries present (or at least express in clinical interaction) a different set of responses raises once again the issue of the social-cultural contextualization of the phenomenon of anorexia nervosa. While the writers of this review aim to solve the problem of the manifestation of anorexia nervosa in non-Western countries by changing slightly the diagnostic scheme of the DSM IV, they do not really contend with the core problem that the original criteria find their source in a Western-centric view of the world. This means that the DSM IV which presents itself as a scientific document which overrides (and ignores and directly marginalizes) cultural/societal contextualization is seen in the review to be unable to contend with the manifestation of anorexia in other cultures. While culture is presented in the data of this review as significant for understanding the manifestation of anorexia nervosa, the final solution of changing the names of categories ignores the importance of culture that led to the need for a change in the categories. This is a glaring oversight and reinterpretation by these specific writers and once again points to the power of the Neo-Kraepelinian disciplinary discourse of psychiatry.

The final review to be addressed in this section is probably the most important from the perspective of what it says about how the field of psychiatry will authoritatively construct anorexia nervosa in the future DSM V as this review was written by the head of the team (Dr. B. Timothy Walsh) that will ultimately make the changes to the text and because it suggests a serious overhaul of the current category system. In other words, this particular review is a recommendation from the head of the DSM-V eating disorders team as to how the diagnostic category system should be changed in the future. From the perspective of this dissertation this particular article provides an insight into how the previous reviews discussed here are going to be assessed, integrated and applied in the new diagnostic criteria of anorexia nervosa.

Walsh and Sysko (2009) situate their proposal for a revised diagnostic category system as a response to the problem that 50% to 70% of all diagnoses within clinical settings are under the heading EDNOS (Eating Disorder Not Otherwise Specified) and that this

category includes patients with very different features. In other words, the current category system does not actually manage to clearly differentiate between cases and the specific category of EDNOS is being used as a diagnostic outlet for any patients that just do not fit the other categories.

The solution posed by Walsh and Sysko (2009) consists of two core principles: 1) a reduction and specification of a limited number of features that need to be assessed for any eating disorder; and 2) the proposal of a tiered hierarchy system of classification based on the severity of the eating disorder. The specific set of dimensions currently proposed as those that need to be considered in the diagnosis of anorexia nervosa consist of the following:

1. "Body mass index
2. Frequency and size of episodes of out of control eating
3. Frequency and nature of inappropriate compensatory behaviors (e.g. self induced vomiting, laxative misuse)
4. Concern about body shape and weight
5. Degree of distress and impairment related to eating disorder symptoms" (Walsh and Sysko, 2009, p. 9)

This limited set of features translates into a reduced set of decisions that clinical psychiatrists need to make in order to conduct a diagnosis. This list also has a hierarchical aspect to it in that as stated by Walsh and Sysko (2009) "the salient distinguishing feature between these categories in the DSM-IV is weight" (p. 3). The decision that was made here was to reduce the category list to really explicit physical and behavioural measures. This is clearly in-line with previous Neo-Kraepelinian guidelines and involves a further reinforcement of these disciplinary positions.

From the perspective of this dissertation, it is revealing that the ample evidence and explicit calls for the inclusion of social and cultural understandings of anorexia as part of the diagnostic process has been completely ignored in this specific set of features. While the argument forwarded is to simplify the diagnostic process, this movement toward supposed increased reliability does not seem to be very concerned with the validity of the proposed system or the referenced problems in relation to cultural understandings of body and weight. In fact the category systems seems to follow closely the guidelines of the reinvented DSM III and explicitly avoid anything that suggests reasons for this disorder focusing exclusively on explicit measures (weight) and behavioural manifestations.

The system as currently proposed by Walsh and Sysko (2009) consists of three broad categories: Anorexia Nervosa and Behaviorally Similar Disorders; Bulimia Nervosa and

Behaviorally Similar Disorders; Binge Eating Disorder and Behaviorally Similar Disorders. Each of these categories is further subdivided into subgroups that are also arranged in hierarchical order and a specific subset of questions defined to clarify how the diagnosis should be conducted. In relation to Anorexia Nervosa and Behaviorally Similar Disorders, the diagnosis rests on the presence of following two core criteria:

> "(1) restriction of food intake (e.g. severe self imposed dieting) relative to caloric requirements resulting in the maintenance of an inappropriately low body weight for the individual taking into account age and height; the maintenance of the inappropriately low weight is not better accounted for by another Axis I disorder or a general medical condition and (2) clinically significant distress or functional impairment related to the eating disturbance" (Walsh and Sysko, 2009, p. 7).

It is important to note that this definition further restricts the core factors that define anorexia nervosa. The focus is on "the restriction of food intake" and "significant distress or functional impairment", both supposedly explicit biological and behavioural indicators. The core symptoms of anorexia nervosa as presented here are completely decontextualized from any mention of gender, cultural or social context. As proposed by Walsh and Sysko (2009) the response to the problem of overly inclusive categorization of anorexia nervosa within the category of EDNOS (Eating Disorder Not Otherwise Specified) is to create a system that is so reduced that it places a wide range of differences under the same heading. The problem with this type of approach is that it erases any differences in the manifestation of anorexia nervosa and thus may hinder the actual therapeutic process bringing into question the whole rational basis for diagnosis in the first place.

The two core criteria proposed by Walsh and Sysko (2009) are further augmented by the construction of prioritized sub-groupings. In all, this revised categorization system proposes 4 sub-groupings: Typical Anorexia Nervosa, Anorexia Nervosa without Evidence of Distortions Related to Body Shape and Weight, Anorexia Nervosa-Behaviorally Similar Disorder with Significant Weight Loss at or above Minimally Accepted Weight, Disorders Behaviorally Similar to Anorexia Nervosa Not Otherwise Classified. The first and presented as most severe form of anorexia nervosa, defined here as "Typical" includes the same criteria as the DSM-IV criteria for anorexia nervosa with the single change that amenorrhea is not required as a diagnostic criteria. This definition retains similar wording as previous definitions and consists of the following:

A. "Severe restriction of food intake relative to caloric requirements leading to maintenance body weight below a minimally normal weight for an individual taking into account age and height (e.g. 85% of that expected).
B. Evidence of intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape or weight on self-evaluation, or denial of the seriousness of current low body weight" (Walsh and Sysko, 2009, p. 10).

Note that the term "refusal to maintain weight" has been replaced with the term "severe restriction of food intake" without the specification of an active agent. This new formulation supposedly reduces the degree of blame and agency assigned to the patient. However, the question still needs to be asked who is "restricting" food intake? The disembodied "severe restriction of food intake" is still manifest in the patient's behaviour and as such this change seems nothing more than a form of political correctness. In addition, as discussed above the same problems of the interpretive nature of the existing categories have not changed.

Each of the other sub-groupings - Anorexia Nervosa without Evidence of Distortions Related to Body Shape and Weight, Anorexia Nervosa-Behaviorally Similar Disorder with Significant Weight Loss at or above Minimally Accepted Weight, Disorders Behaviorally Similar to Anorexia Nervosa Not Otherwise Classified - are defined by the absence of one the three categories defined for typical anorexia nervosa. Sub-grouping two - Anorexia Nervosa without Evidence of Distortions Related to Body Shape and Weight – has the features A and B but not C (restriction of food intake and intense fear of gaining weight without body weight disturbance). Sub-grouping three - Anorexia Nervosa-Behaviorally Similar Disorder with Significant Weight Loss at or above Minimally Accepted Weight – has the features of B (intense fear of gaining weight) and C (body weight disturbance) but does not have the requirement of 85% of expected body weight. The final sub-grouping - Disorders Behaviorally Similar to Anorexia Nervosa Not Otherwise Classified – has only the 85% weight requirement (without any behavioral symptoms). The constructed hierarchy proposes that Typical Anorexia Nervosa is the most severe eating disorder.

As stated by Walsh and Sysko (2009) the revisions they propose are a response to the inability of the DSM IV to provide a reliable diagnostic system as evidenced by the large number of patients placed within the category of EDNOS (Eating Disorder Not Otherwise Specified). Thus, the aim of Walsh and Sysko (2009) is to increase the reliability of the DSM by changing the criteria for diagnosis. They approach this as a technical problem of division and categorization. The process enacted by these researchers and presented in their proposal

involves a strict return to Neo-Kraepelinian guidelines. In particular the current proposal suggests a form of purification and sanitization of the existing diagnostic criteria for anorexia nervosa. The criteria are restricted to weight and distress and the subgroups delineated by reducing the definition of types of anorexia to 1 or 2 of the three proposed criteria for typical anorexia. In so doing Walsh and Sysko (2009) ignore the evidence that was produced in the series of review papers that supposedly are designed to provide a research basis for the redesign of diagnostic criteria. It seems that this process of review and redesign is more influenced by the discursive guidelines of Neo-Kraepelinian psychiatry than it is by presented evidence. This really brings into question the scientific integrity of the DSM revision process.

More importantly, the discursive requirement for a focus on explicit symptoms erases significant information useful for defining, diagnosing and categorizing anorexia nervosa. The movement towards reduction may increase diagnostic reliability but at the price of erasing the real differences between patients and the way these are manifest in their specific form of anorexia nervosa. This also directly involves an avoidance of clearly present research evidence that differences exist. Gender and culture are cases to point. There are cases in which males are diagnosed with anorexia nervosa; however the vast number of anorexic patients are girls. The current proposal hides this distinction. The manifestation of anorexia nervosa in women from non-Western cultures is handled by once again manipulating and reducing the requirements in the category system and does not address the potential differences in relation to patients from different cultures. There is an attempt to background and obscure gender issues and personal agency in general. This is directly expressed in the removal of the amenorrhea category and in the change of the wording "refusal". This enhanced version of Neo-Kraepelinian guidelines directs a process of erasure for the social-cultural aspects of the phenomena of self starving women (and men) and it is interesting that at least in the work of Anne Becker there is ample evidence of the importance of these social components for understanding and diagnosing anorexia nervosa. It seems that Walsh and Sysko (2009) care less about the evidence based descriptors of anorexia nervosa than their desire to follow Neo-Kraepelinian discourse and increase reliability through a vacuous reduced category system.

6.5.5 Summary: The Construction of Anorexia Nervosa in Psychiatric Discourse

The detailed analysis that appears above makes it clear that the DSM is directed by Neo-Kraepelinian guidelines that focus on explicit symptoms, medical explanations, and the rhetoric of science and situate psychiatric phenomena in the individual psyche. As reviewed here, these guidelines are a powerful discursive force that clearly directs the hierarchy of

statements that are accepted as authoritative knowledge. In fact, the difference between the range of possible explanations found in the overview of research articles in 2009 (see section 6.4), the more limited discussion that appears in the review of the DSM-IV (see section 6.5.2) and the final proposal for a revision in the DSM-V (see Walsh and Sysko, 2009) presents a clear example of exactly how disciplinary discursive practices shapes and directs knowledge While the field of psychiatry may entertain various options for the explanation and description of anorexia nervosa, it will be the final version that appears in the DSM-V that will have the definitive role in describing this disorder.

The outcome of these analyses reveals a field that has built its power through the usage of a very specific set of discursive guidelines involving the reorientation of psychiatry towards diagnosis based on Neo-Kraepelinian guidelines. Problematically this disciplinary discourse was found to be more powerful than empirical evidence in directing decisions concerning the definition of anorexia nervosa that appears in the final proposal for changes to the DSM V. Most importantly, disciplinary discourse directed a process in which quite obvious empirical data dealing with the importance of gender and socio-cultural context was ultimately ignored in favour of creating a diagnostic category system that may provide reliability at the price of validity.

At this final stage of this chapter a focused summary and answer to the questions posed at the beginning of the chapter is in order. As discussed in this chapter, the field of psychiatry is currently preparing for the unveiling of the newest version of the DSM. The proposal for the definition of anorexia nervosa to appear in the DSM V involves the movement to a reduced set of criteria which focus on explicit indicators of biology and behaviour (see Walsh and Sysko, 2009). The latest proposal removes the criteria of amenorrhea, ignores any discussion of etiology, avoids assigning agency directly and sanitizes the diagnostic criteria from any mention of gender or socio-cultural context. This creates an interesting dynamic in that it seems that issues of blame concerning women (involving both mother and daughter) has been avoided in the proposed version of the DSM V. This perception is, however, misleading as the changes to the language of the DSM are directed by the desire to construct categories that can be used with statistical reliability and beneath the changes the same basic positions have been maintained.

Broadly the field of psychiatry as seen in the DSM-IV and the proposals for the DSM-V, support a description of anorexia situated in Malson's (1998) categories of *Natural Disease*, *Body Image Distortion*, and *Cognitive Dysfunction*. Anorexia nervosa as reflected in the DSM-IV and proposals for DSM-V focuses on explicit symptoms of the disorder, situates

the disorder in the individual and describes patients who are restricting their food intake in order to reduce their weight. These same patients are described as manifesting cognitive distortions in their understanding of their own weight and body shape and an irrational fear of gaining weight. The objective measure of low weight which cannot be explained except on the basis of the patient's behaviour is seen as the clearest indicator of the phenomenon of anorexia nervosa. As described by Becker, Eddy and Perloe (2009) "both low weight and the cognitive frame that supports it are intrinsic to AN" (p. 615). In other words, anorexia nervosa is an illness that is characterized by the way an individual behaves by restricting the amount of food that they eat as a result of cognitive distortion and irrational fears. In addition, as specified in reviews and the DSM-IV, anorexic patients are not to be trusted in that they may lie and conceal their behaviours and symptoms.

The DSM-IV and the proposals for the DSM-V clearly avoid the assignment of any aetiology to anorexia nervosa and, thus, these diagnostic criteria appear as de-facto components. This process of avoidance can be seen as a continuing movement away from psychodynamic approaches and further decontextualization of the criteria defining anorexia nervosa. However more broadly in the literature and even within the critiques of the existing DSM-IV the social and cultural context of these components is recognized and was even raised as an issue that needs to be directly addressed in diagnosing the cognitive components of anorexia nervosa (see Becker, Eddy, & Perloe, 2009). The social-cultural analyses proposed in this literature deal with the manifestation of anorexia in non-Western cultures and that this is different from the typical ways in which this is manifest in the West. The way this existing literature was handled in the final proposal for diagnostic criteria in the DSM-V consists of reducing the number of required criteria for anorexia nervosa and creating a hierarchy of sub-groupings. This allows a range of diagnoses but does not acknowledge the presence of a social-cultural, gendered component to this disorder. The lack of an explanation of why patients would self starve (which after all is the core of what this psychiatric definition of anorexia states) is deeply troubling even from a diagnostic perspective. Did these patients just wake up one day and decide to starve themselves? It is even more troubling that there is no recognition or explanation why the vast majority of these self starving individuals are women many of who are young and in adolescence. The choice to focus on explicit, decontextualized diagnostic criteria ignores the role of gender and the socio-cultural contextualization of anorexia nervosa and thus avoids central information in understanding and diagnosing this phenomenon.

In relation to the question as to how women are constructed and represented within psychiatric disciplinary understandings of anorexia nervosa, the sanitization of the diagnostic criteria of the DSM-V poses an interesting dynamic of minimizing gendered understandings and distancing psychodynamic explanations. This is a process that was also observed in the corpus of articles from three major journals in 2009. The number of studies dealing with gender was limited to 2. This situation reflects the feminist critical discourse analyst Michele Lazar's (2005) position that gender characterization has become more difficult to analyse in the 21st century as it is better hidden. This, I think, is the case at hand. While specific moves such as the removal of the diagnostic category of amenorrhea under the heading of widening the definition of anorexia nervosa to include men seemingly make this a less gendered category, the presented statistics and vast majority of the studies which construct the knowledge base of the old and new versions of the diagnostic category of anorexia nervosa in the DSM relate to women. In other words, women are still the norm for the construction of this category even if the terminology of the DSM has removed the category of amenorrhea as a requirement. Thus, the definition of anorexia nervosa still by extension reflects on the way women are defined.

A central aspect of the description of anorexia nervosa is still that these patients enter into a process in which they align their self evaluation with physical appearance. Self starvation, the clearest manifestation of anorexia nervosa, is described as the result of a "cognitive frame" and "fear" of weight gain and fatness. Furthermore, these women are described as patients who lie and are deceptive about their symptoms. They are committed to their own process of self starvation and many see this as a source of achievement and even pride. Clinicians are even directed not to trust what these girls say but rather to look for external sources in order to have more reliable information about the patient. The overt characterization of anorexic patients is that of deeply disturbed individuals who suffer from cognitive and affective disorders that direct them to behave irrationally and thus endanger themselves through their eating behaviours. More subtly, the characterization that emerges from this description reflects the historical descriptors of women as deceptive, concerned with physical appearance, deeply irrational and cognitively impaired. Thus, while more deeply hidden in the use of the prose of the current suggestions for the diagnostic criteria of the DSM, the same historical positioning of women is still present.

6.6 Final Comments

In this chapter, the discursive frame of psychiatry was explicated through the discussion of the DSM and the underpinning Neo-Kraepelinian guidelines and this was used to explicate

current disciplinary understandings of anorexia nervosa and the construction of women. In considering this analysis, it is difficult not to feel that current understandings in this field are misguided through the avoidance of the issues of gender and socio-cultural contextualization. The discursive, disciplinary decisions to focus on explicit symptoms, combined with the pressure to avoid aetiology have produced diagnostic descriptors that seem partial at best. This is especially salient since even within the review of the current diagnostic criteria there was recognition of the importance of understanding social and cultural context and how these influence patient understanding. Ironically, the evidence presented by psychiatrists reinforces the idea that both gender and socio-cultural understandings of women's self starvation should be foregrounded. But the role of psychiatric discourse really directed the exclusion of this information preferring the more explicit and decontextualized form of explicit symptoms. Ultimately the field of psychiatry relied too much on their own rhetorical, disciplinary guidelines and this led them to underestimate their own data on the role of gender, culture and society in this phenomenon.

Chapter Seven

Individual Art Therapists Constructing Anorexia Nervosa and Women

7.1 Introduction

In the last chapter, the construction of anorexia nervosa within the discipline of psychiatry was explored. In this and the next chapter, I will turn to the construction of anorexia nervosa and women within the discipline of art therapy. In relation to psychiatry and psychology, Malson's (1998) review provided an adequate backdrop to move directly to the analysis of materials in 2009. For the field of art therapy a comprehensive, discursive and critical discussion of the construction of anorexia nervosa within the field of art therapy does not exist. Accordingly, this and the next chapter mark new territory for the poststructuralist exploration of the construction of the concept of anorexia nervosa and more broadly the field of art therapy.

As a starting point in this exploration, this chapter critically reviews the research papers of individual art therapists who have researched anorexia nervosa. My intent is to explore the historical construction of the concept of anorexia nervosa within the published literature of art therapy and through an analysis of the ways in which the actual art work of self starving women is understood and positioned. I will follow the theoretical guidelines of Hogan's (2001) position on the nature of historical research as a recounting of "many histories spoken by many voices" (p. 25). This approach manifests itself as a detailed and critical analysis of a corpus of materials from specific art therapists who have presented and explained art work from female patients with anorexia. My presentation and analysis of each of these art therapy publications on anorexia also draws on Hogan's (1997) feminist art therapy approach and interacts with each of these papers. As such, this chapter aims to provide detailed and comprehensive information on academic materials within the discipline of art therapy that have constructed anorexia nervosa. The next chapter looks at these materials from a broader perspective and summarizes the discursive influences and historical developments in the art therapy literature in relation to the construction of anorexia nervosa and women.

7.2 Methodological Considerations

As discussed in the methodology section of Chapter Four, the reproductions of eating disordered patients pictures that appear within the published materials of art therapist are accompanied by a set of interpretive verbal statements. The analysis consists of: 1) an examination of the picture itself; 2) an analysis of the verbal interpretive statements made about the pictures; and 3) a consideration of other options for explanation that have been

repressed by the selection and presence of the chosen stated interpretation by the art therapist researcher. In other words, pictures are analysed in relation to the verbal context within which they appear. In relation to verbal interpretive statements the stages of analysis consist of a description of the preferred interpretations, the intertextual history of these statements and the disciplinary guidelines that direct these specific interpretive preferences.

7.3 Description of Corpus

In order to produce a meaningful corpus of materials for the analysis of the disciplinary construction of anorexia nervosa and women in the field of art therapy, a series of core criteria for academic material choice were proposed. These criteria were as follows:

1. The explicit designation that the author of the publication is an art therapist working with female anorectic patients.
2. The usage, interpretation and presentation of visual representations within the published manuscript.
3. Articles, book chapters and books within peer reviewed academic journals and publishing houses.
4. Academic materials that are referenced within the disciplinary literature as a source for understanding and treating anorexia nervosa.

The criteria were designed to help identify published academic research within the field of art therapy that would be useful for the purposes of this dissertation. A compilation of research materials dealing with art therapy and anorexia nervosa was collected using digital search engines and library services. This search produced a relatively small corpus of 16 book chapters, 12 articles and 5 books that dealt with art therapy and eating disorders. This collection of articles was read and considered in relation to the proposed criteria. 17 of the found academic materials were included in the final corpus as they fully met the proposed criteria. Published research that was not used failed to meet one or another of the criteria as they either did not have pictures, were not written by an art therapist, or dealt with male rather than female patients. The final corpus represents the complete set of materials produced within the field of art therapy that meet my criteria for inclusion. This corpus consisted of the following 17 academic materials spanning the years 1980-2008:

Betts, D. J. (2008). Art therapy approaches to working with people who have eating disorders. In Stephanie L. Brooke (Ed.). *The Creative Therapies and Eating Disorders* (pp.12-27). Springfield: Charles C Thomas Publisher Ltd.

Crowl, M., A. (1980). Art therapy with patients suffering from anorexia nervosa. *The Arts in Psychotherapy, 7*, 141-151.

Edwards, C. (2008). Bringing "the world" into the room: Art therapy, women and eating issues. In Stephanie L. Brooke (Ed.). *The Creative Therapies and Eating Disorders* (pp.29-55) Springfield: Charles C Thomas Publisher Ltd.

Fleming, M. M. (1989). Art therapy and anorexia: Experiencing the authentic self. In Lynne M. Hornyak and Ellen K. Baker (Eds.). *Experiential Therapies for Eating Disorders* (pp.279-303). London: Guilford Press.

Hinz, L., D. (2006). *Drawing from Within: Using Art to Treat Eating Disorders.* London: Jessica Kingsley Publishers

Levens, M. (1995). *Eating Disorders and Magical Control of the Body*. New York: Routledge

Luzzato, P. (1994). Anorexia nervosa and art therapy: The "double trap" of the anorexic patient. *The Arts in Psychotherapy, 21* (2), 139-143.

Luzzato, P. (1995). Art therapy and anorexia: The mental double trap of the anorexic patient. The use of art therapy to facilitate psychic change. In Ditty Dokter (Ed.). *Art Therapies and Clients with Eating Disorders: Fragile Board* (pp. 60-75). London, UK: Jessica Kingsley Publishers.

Maclagan, D. (1998). Anorexia: the struggle with the incarnation and the negative sublime. In D. Sandle (Ed.) *Development & diversity: new application in art therapy* (pp. 78-91). New York: Free Association Books.

Makin, S., R. (2000). *More than Just a Meal: The Art of Eating Disorders*. London: Jessica Kingsley Press.

Murphy, J. (1984). The use of art therapy in the treatment of anorexia nervosa. In T. Dalley (Ed.) *Art as therapy: an introduction to the use of art as a therapeutic technique* (pp. 96-109). London: Routledge

Rabin, M. (2003). *Art Therapy and Eating Disorders: The Self as Significant Form*. New York, NY: Columbia University Press

Rehavia-Hanauer, D. (2003). Identifying conflicts of anorexia nervosa as manifested in the art therapy process. *The Arts in Psychotherapy*, 30, 137-149.

Rehavia-Hanauer, D. (2006). "To be or not to be": The central conflicts of the eating disorder anorexia nervosa as they emerged within the process of art therapy. *Therapy through the Arts*, 4 (1), 5-20.

Schaverien, J. (1992). *The Revealing Image*. London: Routledge

Schaverien, J. (1994a). The transactional object: Art psychotherapy in the treatment of anorexia. *British Journal of Psychotherapy*, 11 (1), 46-61

Schaverien, J. (1994b) The picture as transactional object in the treatment of anorexia nervosa. In D. Dokter (Ed.) *Arts Therapies and Clients with Eating Disorders* (pp.31-47). London, UK: Jessica Kingsley.

7.4 Individual Art Therapists Constructing Anorexia Nervosa

In the following sub-sections critical summaries of a series of individual, art therapy materials dealing with anorexia nervosa are presented in their chronological order. The structure of each summary is as follows: 1) a description of the proposed explanation by each art therapist, researcher; 2) an explication and reference to the types of intertextual and disciplinary sources used by this art therapist; and 3) a critical, feminist interaction with the proposed positions. This tri-part approach allows a multiplicity of voices to be heard in the specific analysis of each art therapist as well as across the range of materials that are dealt with. The aim is to avoid the presentation of a history that would read as a progression of objective positions gradually moving forward towards more accurate descriptions of anorexia. Through this approach each art therapist's position on anorexia nervosa is situated within disciplinary discourse that informs it and is qualified in relation to underpinning assumptions that inform the proposed understanding of anorexia.

7.4.1 Marianne A. Crowl (1980)

Crowl an art therapist working within the American context published one article dealing with her clinical work with female patients who suffer from anorexia. Crowl's (1980) theory of anorexia nervosa results from a close consideration of art produced by anorectic patients and the application of theoretical explanations of anorexia nervosa from prior sources (in particular Bruch and Minuchin) to the interpretation and organization of the pictorial data. The data was collected over four years (1975-1979) from 12 hospitalized female patients ranging in age from 11-16 and who were treated for two to four months. Crowl (1980) using existing theories describing anorexia nervosa proposes the following three psychodynamic variables which characterize anorexia nervosa and organize the different patient pictures presented in this article: self image, self esteem, and control. Crowl (1980) states that the "graphic representations by these patients illustrate their symptomatology indicating their personality conflicts underlying the illness which are closely tied to feelings self" (p.141) a position that is referenced as being aligned with that of Bruch (1978). Crowl's basic position situates the condition within the internalized conflictual world of the patient. The pictorial analyses are organized according to self image, self esteem and control.

In relation to the variable of *self image*, Crowl's (1980) explanation of the characteristics of anorexia nervosa is drawn mainly from Bruch's (1978) positions. Crowl

(1980) notes that in the collection of the pictures, some anorectic patients draw themselves as an image of a "little girl" with the commentary that they see themselves as "their parents delightful little girl" (Crowl, 1980, p.141). As shown and described by Crowl (1980), some of the "little girl" images have "smiling faces, immature bodies, girlish decorations of hair ribbons, ruffles and bows". Crowl (1980) connects these pictures to the phenomenon of self starvation by stating "These patients also resisted having a womanly body; and starvation became a way of neutering the body making it less female" (p.143). Referencing an article written in the woman's magazine Cosmopolitan (Meehan, 1977), Crowl (1980) states that the "typical sufferer" of anorexia nervosa is a "high achiever, mother's good girl who tries to conform to perfect standards" (p.143). This description is further reinforced the Crowl's (1980) description of a specific patient in the following terms "She was her mother's little daughter in outward appearance as well as internally accepting the child as her self image" (p.143).

A different issue of self image addressed by Crowl (1980) is that of a split body image. Crowl (1980) explains the split in terms of a conflict between being fat or thin and the "ridicule" attached to each self image. Crowl (1980) states that anorectics feel divided but are reluctant to speak of this split. Referencing the New York Times (Meehan, 1977), Crowl (1980) states that "Physicians and psychiatrists have speculated that the disease is a rejection of adulthood, an attempt to restrict sexual maturity" (p.143). A split body image results from these divided feelings.

In relation to the psychodynamic variable of *self esteem*, Crowl (1980) states that the anorectic patients "display very low self esteem" (p.143). In Crowl's (1980) analysis, low self esteem was indicated at the beginning of the art therapy process when patients made their paper smaller and drew tiny figures. As stated by Crowl (1980) this use of a small surface "implies low self esteem, a feeling of being small and insignificant" (p.144). In addition , Crowl (1980) notes that these patients frequently drew clown figures. Her analysis of this phenomenon is that these patients are trying to make themselves "likeable" but that internally they feel "they are a farce, a joke, a buffoon, a caricarture and not to be taken seriously as they are laughable" (Crowl, 1980, p.144). Crowl (1980) connects this pictorial representation to Bruch's (1962) idea that anorectic patients are in a "desperate struggle for a self respecting identity" (p.144)

In relation to the psychodynamic variable of control, Crowl (1980) references Minuchin at al.'s (1978) idea that the family of an anorexic patient is characterized by rigidity and has difficulty with change and growth. Based on the analysis of the patient's pictures,

Crowl (1980) finds rigidity in the use of "stereotyped symbols, rote repetition, and decorative art" (pp.144-7). Using Bruch's (1978) theory she explains this phenomenon in terms of the need for control. As stated by Crowl (1980) the anorectic patient must "control the unruly and despised body" (p.147). According to Crowl (1980) this situation is graphically displayed in one particular painting in which a situation of slavery with a patient self representing herself tied up to heavy chains is presented. The second figure in this painting pointing to the chained figure, is explained by Crowl as a representation of "external control from without" (p.147). Referencing the New York Times (1978), Crowl (1980) states that "the anorexic girl wants to gain complete control of her biological, physiological and emotional reasons to eat" (p.147). According to Crowl (1980), this issue of control is also represented in images of robots. Referencing Bruch (1978), Crowl (1980) explains that the "patient feels and recognizes the body as her own, but controls it as if it were not" (p.147). Crowl (1980) sees the issue of control as a form of obsessive-compulsive behaviour that is characteristic of anorectic patients. Obsessive compulsive behaviour can be found in the technique of drawing used by Crowl's (1980) patients.

In her summary, Crowl (1980) situates the source of anorexia nervosa in the structure of the family. As stated by Crowl (1980) "the pre-anorexic feels controlled by her parents" (p.150). Crowl (1980) references both "a controlling, rejecting mother" and a "rigid, perfectionist Father" (p.150). The outcome of this family structure is a child in "desperate need to take control" (p.150). According to Crowl (1980) what the child can control is the size and shape of her body. Crowl (1980) agreeing with Bruch (1978), also discusses the anorexic's control of her family through her worrying behaviour that activates her parents over protectiveness. Thus, the anorectic girl reverses the power relations and "experiences that she has power and is in control" (p.150). A different aspect of this search for control and power relates to body image. Based on Bruch (1978), Crowl (1980) states that anorectic patients have a distorted body image and they have "delusional proportions in the body image" (p.150). Self esteem, according to Crowl (1980) is "elevated by the anorectic's ability to control their bodies" (p.151). The anorectic girl's thinness is a source of "extraordinary pride" and a "supreme achievement" (p.151). According to Crowl (1980), the control over the body brings with it a sense of power that enhances the "feeling of being significant" (p.151).

Crowl's (1980) description of the art of the girls who suffer from anorexia nervosa involves the description of their difficult personal experience and the erasure of this experience through the application of psychological theory. The negotiated experience of the girls was superseded by the explanation of the art work as evidence of internal

psychodynamic states. Without the theoretical layering of Crowl (1980) the experience revealed in these pictures consists of a deep rooted sense of themselves as worthless, marginalized and controlled by others. The collection of images depicted in these pictures consists of little girls, aliens, robots, clowns and a slave. As discussed above, these images are organized by Crowl (1980) into the representational categories of low self esteem, childish self image and the need for control. But this is a significant collection of images in itself. As described by Crowl (1980) the little girls "conform" to societal standards while not accepting images of self that would designate an older female sexual role. Aliens, clowns, robots and slaves are all dehumanized images. The presentation of these images as representative of the art of anorexia designates the experience of being (or feeling) dehumanized. In addition as specified by Crowl (1980) both the clown and the slave involve degrees of degradation and humiliation. Crowl (1980) points out that these girls have a deep desire to be 'respected" signifying the sense of their own subjective experience of being disrespected. Little girls and slaves are characterized by their dependence on others and patronizing 'parental' control and thus represent a sense of a lack of control. In Crowl's analysis these experiences are directed towards psychological theories that blame mothers and the family structure and define these girls as manipulative and flawed. As seen in the quotes above, controlling mothers are to blame for the anorexic girls desire to stay a little girl and her sense of being controlled. According to Crowl, it is the family structure and over protectiveness that directs these girls to respond by controlling their body size. The girls feelings and experiences expressed and analysed in relation to the presented art work is transformed into the assignment of blame on the families through the application of psychological theory. Gimlin (1994) in an alternative sociological explanation of anorexia nervosa points out that psychoanalytic and family theories (such as those of Bruch and Minuchin) have avoided the influential social contextualization of the family and its members. As stated by Gimlin (1994) the "social origins of personalities, relationships and family configurations are ignored" by psychoanalytic and family theories of anorexia. This critique of family blame has been termed by Currie (1985) as the "fallacy of autonomy" defined as "the belief that what goes on in the family can be meaningfully separated from the forces that affect it from the outside" (p.185). Specifically in relation to anorexia, families function as conduits for broader normative social gender assumptions that are impossible to fulfil. Gimlin (1994) offers the explanation that anorexia results from an overconformist acceptance on the part of the girl who suffers from anorexia of the contradictions that are inherent in the socially promoted role of women as "mature, yet childlike; sexual, yet neutral;

competent, yet passive" (p.103). Thus, the psychoanalytic and family explanations of anorexia utilized by Crowl are criticized for their short-sightedness in relation to the discursive social forces that constitute the individual and the family and for their family and mother blaming tendencies.

In her artistic analysis of the art works of anorexic patients, Crowl defined the subjective negotiated experiences of these girls as feelings of being worthless, disrespected, degraded, humiliated and controlled. Within Crowl's (1980) explanation these characteristics result from an over controlling and rigid family structure and manifest themselves in extreme control over the body. Thus, anorexia becomes a way of achieving enhanced self esteem against this emotional backdrop of a sense of personal worthlessness. While not stated, this direction in interpreting anorexic behaviour ignores the discursive, social and gendered inscription of value on a very particular body type and the possibility of personal agency in 'crafting' the body (Bordo, 1985; Gremillion, 2002). As argued by Ussher (1989) physical developments in the woman's body at puberty, such as the development of breasts, are semantically tied to limiting gendered identity values. The changes in women at puberty are seen as offensive and consisting of a shift in personal, female identity towards the role of the reproduction. This limits women's identity to a biological role and defines women as weak in relation to men resulting in a negative self image (Ussher, 1989). On this basis Bordo (1985) describes anorexia as a process through which girls with anorexia attempt to regain self value by transforming their physical bodies through the erasure of signs of femininity. As stated by Bordo (1985) as the body of girls "begins to lose its traditional feminine curves, its breasts and hips and rounded stomach, begins to feel and look more like a spare, lanky male body, she begins to feel untouchable, out of reach of hurt" (p.178). The development of the female body brings with it the vulnerability of the discursive construction of women and sexuality in society. What Crowl (1980) ignores in her analysis is the wider discursive context within which women's bodies are constructed. A feminist analysis would direct attention to the unjust social construction of women in society with their assigned subordinate roles and subjection to sexual requirements. Behind Crowl's (1980) analysis is an assumption that the 'real' world of these girls is just and secure. In other words, if these girls feel threatened or dehumanized and worthless (as in the case of Crowl), this results from an individual distortion by the anorectic patient as a result of problematic childhood and family experiences and not as a result of the discursive environment that she is exposed to. Crowl's assumption is further supported by the application of psychological theory that offers explanations that reconstruct these experiences as outcomes of early developmental and familial experiences.

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Figure 7.1 Pictures Addressed in Crowl's (1980) Analysis of Anorexic Art

7.4.2 Jane Murphy (1984)

Jane Murphy is an art therapist working within the British context. She published an early paper relating to the art therapy and the treatment of anorexia nervosa. In her 1984 paper Murphy presents both psychological and psychiatric medical definitions of anorexia nervosa. As stated by Murphy (1984) "True anorexia is based on three diagnostic criteria defined by Russell (1979): self-induced loss of weight with severe inanition, persistent amenorrhea (or an equivalent endocrine disturbance in the male), and a psychopathology characterized by a dread of losing control of eating and becoming fat" (p.97). Having referenced these medical and behavioural definitions of anorexia nervosa, Murphy (1984) states that "In the majority of cases, there is evidence of an abnormal relationship between the anorexic and her mother. The mother is excessively anxious about the well-being of her daughter" (p.97). Later in the same discussion Murphy states that the "over-protective mother can never conceive of the child as a person in her own right, with original needs of her own" (p.99). According to Murphy the mother-daughter relationship is a central factor in the development of anorexia nervosa.

In defining her understanding of anorexia nervosa Murphy (1984) also signifies a role for the onset of sexuality in the development of anorexia. As stated by Murphy (1984) "the pubescent daughter feels her changing body is frustrating her unconscious desire to remain a child" (p.97). Murphy (1984) references two published testimonies of patients who suffer from anorexia that describe and analyse their own experiences. Murphy (1984) describes the first of these descriptions as involving a rejection of "womanhood by reversing her own natural biological process" and how this led to a sense of becoming 'pure' and 'clean' (p.97). For the second of these testimonies Murphy (1984) presents the following direct quote: "nature is impressing upon the girl the sexual function in society. By refusing food either she is subconsciously rejecting the function and finding escape in starvation so what she loses are the two assets peculiar to women, breast and fertility; or so she does not yet feel mentally

equipped for it" (Dunsieth, 1978:169; quoted in Murphy, 1984:98). Murphy (1984) introduces this quote with the statement that Dunsieth could be seen as viewing anorexia nervosa as "the physical indication of a silent protest, and one against a permissive society or the inevitability of womanhood" (p.98).

Another aspect of anorexia nervosa specified by Murphy (1984) is that of 'distorted perception' of self body image. As stated by Murphy (1984) "anorexics constantly see themselves as overweight when, in reality, they are emaciated" (p.98). Mothers are directly blamed for the development of a 'distorted' body image. As stated by Murphy (1984) the "mother's attitudes and reactions to bodily functions other than eating can be highly significant and greatly influence her daughter" (p.98). Murphy developing Bruch's (1974) position on anorexia further blames mothers of girls with anorexia for their early mothering abilities. As stated by Murphy (1984) the disturbance in the perception of body image "may stem from being incorrectly 'programmed' from childhood – the true anorexic has had few opportunities to correlate hunger with the need for food. From infancy, the mother has responded to every sign of anxiety from the child by pushing food into her mouth, thereby preventing the natural learning process of adopting appropriate behaviour to satisfy bodily needs" (p.99).

Murphy (1984) characterizes the girls who suffer from anorexia as a "person physically emaciated with deeply entrenched social and psychological problems" (p.100). These psychological problems address self body image, as well as the need for control. As stated by Murphy (1984) "In the case of the anorexic, the issue of control is central; she wants to remain in control of herself and attempts to control other people by preventing them controlling her" (p.101). Murphy (1984) continues to point out that "In some cases, the fear of losing control is tantamount to the fear of losing her whole existence" (p.101). The need for control in the girl who suffers from anorexia is connected by Murphy (1984) to the issue of the anorexic patient's defensiveness which Murphy sees as a hindrance to the patient's ability to receive treatment. The girl who suffers from anorexia is presented by Murphy as deeply flawed, controlling and manipulative; this state is presented as the outcome of problematic early mothering and the mother's on-going anxiety concerning her daughter.

In relation to treatment, Murphy (1984) sees art therapy as having a role through its use of an alternative medium of communication. The value of the art work is found within its ability to provide a "safer, less threatening arena" within which feelings such as "anger, depression and fear" and unconscious material such as "fantasies" and "self-image" (p.100) can be embodied. Another advantage of art work is that it can address and overcome the

girls' defiance of therapy. As stated by Murphy (1984) "The actual process of painting helps to break down the defensive/defiant mechanism that operates in the early stages of treatment" (p.101). Murphy's use of the term "break down" suggests a rather aggressive approach to the treatment of the girl who suffers from anorexia forcing her to overcome her resistance. Murphy (1984) does not understand resistance as part of a wider socio-cultural process which positions girls in particular ways but rather as a power relationship limited to the context of the art therapist, art work and patient. This characterization of therapy as a relationship of power is further extended by Murphy when she states "By expressing herself in this way, the confusion and ambivalence which the anorexic tries to conceal will be externalized on paper" (p.101). The girl who suffers from anorexia is being described once again as manipulative through the ways in which she 'conceals' her thoughts. As described by Murphy (1984) the commitment to paper in the art therapy process is a commitment to therapy as well. Murphy's concept of therapy is coercive and to a certain extent is based on making the girl who suffers from anorexia submissive to the art therapist. As stated by Murphy (1984) "The activity of painting erodes defensive barriers and thus has the cathartic effect of allowing feelings to be expressed" (p.101). According to Murphy, these characteristics of art therapy make it a suitable therapy for working with anorexic patients.

Referencing an unpublished paper by Diane Waller (1981) a senior art therapist from Goldsmith College, Murphy (1984) specifies a series of picture themes that she considers to be representative of anorexic art. Murphy (1984) specifies that anorexics "rarely drew human figures" in their art work and had "difficulty if asked to do so" (p.103). When a figure was drawn "it tended to be either long, thin and boy like or a caricatured, doll like girl with long hair and nipped in the waist, usually standing in a bed of flowers" (Murphy, 1984:103). Murphy (1984) understands this self representation as a "failure of the anorexic to accept a real sexual identity" and quotes Jeammet (1981) who defines the described body types as "a fetish body; phallic in nature, erect and immutable" (p.118; quoted in Murphy, 1984:103). An additional characteristic of the art work of patients' with anorexia specified by Murphy (1984) from the unpublished Waller paper consists of "images of isolation" and pictures which reference experiences of being "bullied and ridiculed" (p.103). Murphy (1984) understands these images as reflecting the anorexic girls "stark social environment within the confinement of the family and generally her lack of social interaction" (p.103). She also specifies a series of motifs that appeared in a variety of the patients art work. These motifs consisted of "concise extrinsic patterns" (such as whirlpools); animals (usually dogs and horses); flowers and plants; & landscapes and gardens. Murphy (1984) suggests that while it

is difficult to know what these motifs actually mean, it is possible that "they reflect various stages of the anorexic condition" (p.104).

Murphy's (1984) construction of this disorder blames mothers for their early and on-going mothering abilities and defines the anorexic patient as controlling, manipulative and cognitively distorted. Although not directly referenced in her paper, Murphy's theory of anorexia and her directions for treatment are couched in the terms and theories of early 20th century psychoanalytical approaches to anorexia nervosa and accordingly, suffer from the same misogynous assumptions and attitudes. Vander Ven & Vander Ven (2003) summarize the psychoanalytical analysis of anorexia as constructed around the concept of the 'bad mother' who is characterized as "overbearing, controlling, insensitive to her daughters needs" (p.102). Specifically, psychoanalytic theory blames anorexic mothers because they "failed her daughter in infancy by not feeding her properly" and because the mother is seen as "incapable of meeting her child's fundamental need to be nourished" (Vander Ven & Vander Ven, 2003, p.102). As argued by Vander Ven & Vander Ven (2003) mother's blame is inherent to psychoanalytical theories during this period.

An important part of the psychoanalytic position on anorexia is the way sexuality is understood. As presented by Vander Ven & Vander Ven (2003) for psychoanalysis "the suppression of hunger instincts is entangled with the suppression of sexual impulses. The self-starving girl denies herself food, in part, because she equates food with sex" (p.103). Murphy's use of Jeammet's (1981) body definition draws on the earlier psychoanalytical position from Abrams (1924) who claimed that the thinness of the anorexic's body is identified with a penis. Farrell (1995) positions this discussion of anorexia and the male penis as a discussion of the oedipal stage of development. According to Farrell (1995), the identification of the anorexic body as a penis can be understood in two ways: 1) as a wish for a baby from the father; or 2) the desire to be a male (to have a penis). As argued by Chodorow (1978) in a classic critique of Freudian thought, the central position of the penis and assumptions of male physiological "superiority" is inherently misogynous. In other words, Murphy's position on anorexia is constructed from psychoanalytical positions that have a predetermined devaluing of women.

This misogynous psychoanalytical couching of underpinning concepts has direct effects on Murphy's presented understandings. Within Murphy's (1984) descriptions of art work produced by girls with anorexia the themes of girls facing hostility, isolation and fulfilling stereotypical gender roles can be found. However, Murphy redirects all of these explanations back to accusations against the mother. In particular the fear of sexuality and its

social ramifications explicitly expressed by the testimony of two published anorexic patients is repositioned by Murphy as a rejection of a 'natural biological process' and a protest against 'permissive society'. Without saying so, Murphy presents her own unquestioning acceptance of the social defined reproductive and sexual role of women. There is no consideration, by Murphy (1984), of the role of patriarchal society in defining specific gender roles and how these may influence fear of the onset of sexuality. Instead, the idea that womanhood and its associated concept of a sexual role is a natural biological process is presented by Murphy. This underpinning assumption about woman's 'natural' role is highly problematic as it ignores the discursive, social construction of gender. Further, as argued by Hogan (2003) the biological position is often used to enforce discriminatory gender roles.

This underpinning concept of gender also informs Murphy's concept of art therapy. The overall direction and conception of therapy is one of 'breaking' the defences of the patient and making her conform to normative adult sexual roles without any reflection on the nature of these roles and how they may serve a patriarchal society. Murphy's use of psychological theory with its predefined gender roles is used to obscure the explicit statements of women's fear. Ultimately the therapeutic position taken by Murphy is similar to what she critiques as the 'traditional' model of therapy in which the therapist must consistently force the girl to behave in particular ways. In this sense, Murphy is taking on the male role of subordinating her female patient and directing her to conform to the dictates of patriarchal society. While Murphy (1984) states that the therapist must understand the anorexic's defiance as part of the disorder and must try to avoid a power struggle, her concept of using art to break the defence mechanisms of the girl and her aim to bring the girl towards acceptance of natural reproductive roles has the same outcome. Ultimately, Murphy is directed by her acceptance of the underpinning misogynous assumptions of psychoanalysis.

7.4.3 Mari M. Fleming (1989)

Mari Fleming is an art therapist working within the American context who published an early description of the role of art therapy with patients who suffer from anorexia. Fleming (1989) starts her description of anorexia nervosa by quoting Bruch (1985). Fleming (1989) describes anorexia nervosa as "an underlying disturbance in the development of the self, an identity and autonomy" (p.279). This position explaining anorexia is based on an object relations understanding of human development and involves an implicit accusation against mothers. Fleming's theory is built on Goodsitt's (1985) and Kohut's (1971) self-object theory concerning the development of self structure. The self is conceived as "a cohesive unit that includes id-drives, ego, interests, and superego values; an experiencing self; and a self

regulatory structure" (Fleming, 1989: 280). According to this theory, appropriate development of a "cohesive self that can tolerate separation" can only happen if the mental functions of "the capacity to provide one's own cohesiveness, soothing vitalization, narcissistic equilibrium, ... tension regulation, and self-esteem regulation" (Fleming, 1989:280) are internalized during early development. As defined by Fleming the mother and early mothering experiences have a central role in the development of these abilities. The main assumption of the theory is that problematic early mothering experiences results in a deficiency of the self. Based on this principle, the development of anorexia nervosa which is seen as a deficiency in the self is the result of problematic early childhood mothering experiences.

In the case study presented within Fleming's (1989) chapter, blame is consistently and directly assigned to the mother. Quoting her patient (named Crystal), the mother is accused of a lack of "empathy", of not providing a "responsive early environment", of generating Crystal's feelings that her sexual areas are "negative", of being absent when she was a child, of being intrusive and "knowing her every thought", of abandonment, and of calling her "bad" and "dirty" when Crystal expressed independence. Fleming (1989) summarizes this litany of accusations with the statement that "Crystal's mother, alternatively intrusive or withdrawn due to illness, could not meet Crystal's early needs for empathic mirroring and provision of regulatory functions. Crystal had been unable to develop an internal structure that provided self soothing, tension regulation, and self-esteem regulation. Her mother's hospitalizations had threatened Crystal's inadequate sense of self, and Crystal had retreated to taking care of both her ill mother and depressed father" (p.297). It should be noted that while Crystal may have indeed had a difficult childhood, Fleming (1989) has chosen this specific case study to represent her views of anorexia nervosa and the sources of this disorder and as such exemplifies through this case her theoretical assumptions about the roles of mothers in creating anorexia nervosa. Fleming's theory of anorexia nervosa constituted within object relations theory and self psychology assigns blame directly to the mother of the patient who suffers from anorexia.

According to Fleming (1989) art therapy can offer a solution to patients who suffer from anorexia as "a means for the anorectic individual to integrate an authentic self within a stable self-structure" (p.282). Art therapy can help to "increase the patient's awareness of unrecognized and unacknowledged feelings, as an outlet for expression, to increase self control, for mastery over impulses and fears and to incorporate the art therapist as a self object" (Fleming, 1989:282). The art therapist is positioned as a replacement for the patient's

mother. As stated by Fleming (1989) as "does the 'good enough' mother, the art therapist supports the patient's risk taking and solution finding" (p.283) and it is the art therapist role to fill "deficit in the patient's self" (p.279). Fleming (1989) proposes a three stage model of art therapy based on object relations and self psychology concept of appropriate development that is modelled by the art therapist as a replacement mother. At the beginning stage, the art therapist should facilitate a "non-threatening holding environment" that develops an "empathetic understanding of the patient's experience" and "mirrors the patient's art expression" (p.283). At the mid-stage of therapy, the "art therapist, through confirming and mirroring the patient's expression, serves as the self object" (p.284). During this stage "the patient begins to work through repressed needs and wishes, re-enacting her defenses" (p.284). The art therapist is an "auxiliary ego", "assists the patient in overcoming frustration or regression" and "reinforces experiences of mastery, supporting self-esteem" (p.284). In the final ("termination") stage of therapy, the art therapist helps the patient to explore and understand "separation anxiety, rage and guilt" in relation to previous experiences and directs the patient towards "constructive defenses" (p.285).

In the case study of Crystal, Fleming (1989) presents and analyses 8 art works that follow the different defined stages of the art therapy process. Under the heading of the beginning of therapy, Fleming (1989) presents the picture in Figure 7.2 which she describes as "a slim child like figure with tiny golden sun inside her brain" and "Five large hands reached to grab her 'yellow essence' which she had drawn inside her heart" (p.287). Fleming (1989) cites her patient as saying in relation to this picture that felt "helpless and discomfort when her parents drank and fought" (p.287). Fleming's conclusion in relation to this painting is that "Crystal has not experienced an empathic and responsive early environment" (p.288). In the mid stage of therapy, Fleming (1989) describes an art therapy exercise in which patients are required to "picture liked and disliked aspects of their bodies" (p.289). As reported by Fleming (1989), Crystal "pictured her 'worst parts,' the sexualized pelvis and breast areas, in black" (p.289). Fleming interprets the black colour to represent "negative body feelings that indicated possible early loss or separation" (p.289). She then goes on to cite, Crystals beliefs about woman's bodies. As stated by Fleming (1989) Crystal said her mother felt that "It's a man's world" and that "Men only want one thing" (p.290). She further goes on that her grandmother stated that a woman should "keep her figure and be self-sufficient" (p.290). Fleming's summary of these responses is that "These views were reflected in Crystal's identification of her sexual areas as negative" (p.290).

As exemplified in the discussion of these pictures, Fleming's use of theory directs all interpretations back to the core accusatory assumption that Crystal's mother is to blame for her illness. But these two specific pictures raise interesting questions. In the second case, Crystal clearly is concerned with her sexuality and has internalized a series of negative responses to her sexual body parts. Fleming immediately assigns this to the role of the mother and the grandmother as if Crystal lived in an environment isolated from any patriarchal discursive influences. Her mother's statement clearly reflects a sense of an environment that is hostile to women. But rather than directly address this, the mother is presented not as a messenger but rather as the cause of these fears. In fact Fleming goes on to say that these negative body feelings result from early separation from her mother and not any discursive construct of gender and sexuality. In a similar way the first picture explicitly depicts hands reaching for a body that could easily be interpreted as a persecutory image in which hands are trying to take something from the girl and may represent this sense of potential danger. This is interpreted by Fleming as her lack of an early empathic family setting. Fleming's use of theory directs all her interpretations towards accusatory blame against Crystal's mother.

Flemings (1989) description of anorexia and its treatment presents girls who suffer from anorexia as deficient and blames their mothers for this situation. As argued by Bordo (1993) developmental approaches "conceptualized interactions between mother and child as occurring outside cultural time and space; the father's role was simply ignored" (p.45). The usage of object relations and self psychology theory creates a predefined disposition to relate all experiences and feelings to early mothering experiences. This predisposition results in a theory of anorexia nervosa that obscures all other ways of constructing the situation of the anorexic patient and constructs the mother in a secondary and highly problematic way. The mother is first accused of being the source of the psychological problem and is then replaced by the therapist. This erasure of the mother and replacement by the female art therapist can be seen as an application by the therapist of her own internalized gender roles with the female therapist becoming the mother. Unfortunately, this further enhances the secondary position of the mother and makes her worthless. Issues of gender and the discursive construction of sexuality and male society are ignored with all explanations directed back at the faulty role of the mother.

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Figure 7.2 A Picture addressed in Fleming's (1989) Analysis of Anorexic Art

7.4.4 Paola Luzzatto (1994a, 1994b)

Luzzatto (1994a, 1994b) a senior art therapist working in England presents an understanding of anorexia nervosa in two closely related papers - one a journal article (1994a) and one as a book chapter (1994b). In all, there are four different pictures reproduced in the two publications (see Figure 7.3). The basic analysis conducted by Luzzatto consists of an analysis of the compositional, schematic and structural relations between specific components depicted in the pictures chosen by Luzzatto as representative of the art work of her patients who suffer from anorexia. Luzzatto specifies a specific set of structural relations as characteristic of art produced by girls with anorexia which she terms the double trap - "a self-representation based on the image of a special trapping situation' (Luzzatto, 1994b:60). According to Luzzatto (1994b) the double trap image is "recurrent among anorexic patients, and may well illustrate the basic pattern of relationship, or the core issue in many of these patients" (p.62).

Using the concept of symbolism, Luzzatto (1994b) specifies the presence of three core components that are found in these pictures: the self, the prison and the persecutor. The self is described as fragile and frightened. As stated by Luzzatto (1994b) "The self is visualized as something quiet small, vulnerable, often precious" (p.62). In her earlier representation of this theory she defines the self as "The victim: It looks immature and fragile, almost boneless, and sexless" (Luzzatto, 1994a:139). In relation to the concept of a prison, Luzzatto (1994b) states that the "self is contained inside a prison, or imprisoned by somebody, or by a group of objects. The prison has at the same time a negative and positive meaning: negative because it is prison, positive because it is also a protective barrier against the persecutor" (p.62). In her earlier discussion of the concept of the prison in the double trap, Luzzatto (1994a) defines the prison as a "protective trap: The victim seems to be contained by the trap or the trapping position... ...it may be seen as a protective prison or a second skin for a little self who does not know where its boundaries are" (p.140). The concept of the

persecutor is defined as "something threatening or persecutory in the external world (it is often visualized as an aggressive shape, or a threatening color or a devouring animal). The persecutor is ready to attack the self, in case the self should escape the prison" (pp. 62-3). Later in the same chapter, Luzzatto (1995) explicates that she understands "Persecution as an image of relationship with a bad object" (p.65).

The double trap involves a relationship between the three components of the self, the prison and the persecutor. As stated by Luzzatto (1994b) the double trap is a "vulnerable self is imprisoned, but cannot escape, because a persecutor is out there, and no reliable good object is around" (pp.73-74). Both the persecutor and the prison represent trapping situations. As defined by Luzzatto (1994a, 1994b) the prison while necessary to protect against the persecutor is in itself a trap for the self. The outcome of the double trap is immobility and unwillingness to change on the part of the patient and it is "the only position that allows survival" (Luzzatto,1994a, p.2).

As can be seen in these quotes from Luzzatto (1994a, 1994b), her analysis of the structural relations and symbolic components of the art work of patients who suffer from anorexia is infused with concepts from object relations theory. Explicitly, Luzzatto (1994b) quoting Guntrip (1982) describes the double trap as "a static closed sado-masochistic system of internal bad object" (p.64). The double trap "may be seen to represent an internalized object-relationship of these patients and their emotional position towards themselves and toward the world" (Luzzatto, 1994a:141). Luzzatto (1994a, 1994b) further describes this situation as a result of a child's experience of a hostile environment without protection. In this environment the child is terrified and identified with the 'bad object.' According to Luzzatto (1995) this identification with a bad object is better than "no object at all" (p.65). As stated by Luzzatto (1995) "The internalization and identification with a persecutory object may become a defence against the fear of non-existing" (p.65). Anorexia nervosa is described as a symptom of a deeper disorder. The core disorder is described as the presence of a weak-ego and a core fear of non-existence. Luzzatto (1995) states that she "understands the basic fear of the anorectic patient as a fear of ego-weakness more than a fear of persecution" (p65).

Luzzatto's (1994a, 1994b) application of object relations theory to her analysis is a process through which the core experience of a sense of persecution and entrapment is gradually erased through the layering of theory. In the initial stages of her analysis, Luzzatto's presented the understanding that these pictures by her patients describe a sense of persecution and entrapment as a characteristic feeling and experience of anorectic girls. In other words, Luzzatto in her analysis first describes the art work as an expression of the

artist-patient's negotiation and presentation of their core experience. However, this way of positioning the art work as negotiated experience was superseded in Luzzatto's analysis by positioning the art work as a representation of an internal psychodynamic state. This described sense of persecution as the result of the presence of aggressors, is translated into the abstract concept of a 'weak-ego" and identification with a "bad object". In other words, there is a shift from positioning the art work as subjective experience to the positioning art as the representation of psychodynamic states. This shift brings with it a series of discursive ramifications. Of particular importance is the way the core issues of gender in anorexia are understood. It should be noted that the concept of a bad object is related to the role of the mother in early childhood within the object relations literature (Guntrip, 1982). Accordingly through Luzzatto's usage and application of object relations the expressed sense of persecution and presence of aggressors is replaced with a theory of bad mothering and personal failing.

This shift from expressed experience to discussions of early childhood is characteristic of the approach of object relations and has been critiqued by feminist scholars. The feminist critic Burack (1992) stated that "objects relations endows fantasy (intrapsychic life) with more significance than reality" (p.502). This exclusive emphasis on intrapsychic life distances contextualized understandings of women within the world. Rather than a discussion of the oppressive positioning of women within social contexts, object relations emphasizes a decontextualized mother child-dyad as the source of all psychological development (Spelman, 1988). Furthermore, within the theory of object relations the concept of the child and mother is presented in normative, universalist terms and as argued by Ruddick (1989) and discussed by Burack (1992) "assumes a certain 'generic' self that is, in fact, white and male" (p.500). The core position of object-relations theory is that all psychological disorders result from early mothering relationships that are constructed on the basis of patriarchal assumptions of the mother as staying home and the sole authority in raising the child (Fee, 1986).This construction of psychological disorders as resulting from early childhood experience and the situating of the mother as the sole parental authority in charge of the infant, creates a situation in which mothers are constructed as what Hare-Mustin (1987) terms a 'noxious influence'. In other words, the theoretical constructs of object relations inherently involve a system of mother blaming and directly make her responsible for all the psychological disorders that may appear later in her child's life. As such, the theory of object relations has a misogynist aspect to it.

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Without the application of object relations theory found in Luzzatto and just by considering the structural and symbolic analysis conducted by Luzzatto, we would conclude that these girls feel threatened and are frightened by the presence of forces of aggression within their worlds. But Luzzatto (1994b) in accordance with other applications of object relations erases and obscures the presence of 'real' aggressors in the world when she states "I understand Persecution as an image of a relationship with a bad object" (p.65). In other words, the girl is at fault as a result of negative early mothering experiences and is now recreating her early sense of persecution at the hand of her mother. Rather than obscuring the expressed experience of persecution, a central question that could be asked of these girls is what exactly are they frightened of and who is persecuting them? A feminist approach to this issue would look closely at the subjective experience of these girls and consider the social environment within which they appear. On a symbolic level, there is much to fear as a girl growing up within a patriarchal society with its emphasis on female sexuality. But in Luzzatto's analysis in a series of conceptual moves, blame is shifted away from the social experience and is passed to the mother and her early mothering skills. Ultimately, the definition of anorexia nervosa that emerges from this analysis of the art work situates the cause of the disorder within early childhood experiences blaming the mother and defining the daughter as deeply flawed as a result of her early dyadic relationship with her mother. As stated by Luzzatto (1994a) anorexia "is characterized by the co-presence of more than one negative object of a persecutory nature and by the absence of an internalized good object. This makes the external world very frightening and the patient seems to have taken the decision of a defensive immobility as the only position that allows survival" (p.143). Luzzatto's analysis does not consider the social position of young women in the world and the possibility that they do indeed face aggression and are persecuted both externally and through the internalization of messages dealing with the gender roles that they are required to fulfil. The use of object relations theory ultimately passes blame to the mother and reconstructs the anorectic girl as deeply, personally flawed.

Figure 7.3 Pictorial Representations of the 'Double Trap" as addressed in Luzatto (1994a, 1994b).

7.4.5 Joy Schaverien (1992, 1994a, 1994b)

Joy Schaverien is a well known, widely published and established art therapist working within the British context. In explaining the phenomenon of anorexia nervosa, Schaverien's (1992, 1994a, 1994b) draws heavily on psychological theory. Schaverien defines anorexia in the following way: "The anorectic might be understood as suffering from a form of borderline disturbance characterized by a powerful defence system and distorted relationship to her body. In place of an imaginal world the anorexic has her own symbolic rituals, ideas and actions connected to food. These are ways of concretising her experience. She exerts control through ingeniously designed patterns of monitoring intake and excretion of food... ...The whole effort is directed towards control of the uncontrollable: the body, other people, and ultimately life and death" (1994a, p51; 1992, p. 33-34). Schaverien's theory of anorexia nervosa is based on the concepts of a borderline personality, defence mechanism and distorted relationship to her body. These concepts are drawn from developmental object-relations theory that situates the cause of anorexia nervosa within early childhood relationship experiences. The girl who suffers from anorexia is characterized through her need to control herself and her surroundings. As stated by Schaverien (1994a) the anorexic is "terrified of loss of control and so fragmentation, the anorexic is frozen on the borderline between life and death or control and madness" (p. 51).

A borderline disorder within object relations theory results from issues with early mothering experiences. In explaining her understanding of anorexia nervosa Schaverien (1994a) enters into an explanation of the nature of early mothering. As stated by Schaverien (1994a) a child's independence "can only be achieved if the mother can provide a base to which the child may safely return" (p.51). Within object relations, the sense of a loss of control and fear of self fragmentation are results of the role of the mother in the early developmental experiences. In relation to Schaverien's (1992, 1994a, 1994b) explanation of anorexia nervosa she both draws on implicit accusations of blame against mothers (situated in her use of object relation theory) as well as direct accusations against mothers. Schaverien (1994a) states that "The anorexic's control of the world, via food, could be understood as an extension of this ability to interest her immediate maternal environment through her refusal to eat. This evokes the mother's primitive anxiety, her need to respond and ensure survival of her child. The mother's ambivalence regarding the adolescent daughter's impending sexuality and separation from her may be a contributory factor in this anxiety" (p.51-2). In this

formulation, patients with anorexia are presented as manipulative and disordered as a result of mothering experiences. According to Schaverien, girls who suffer from anorexia use food to make their mother's pay attention to them and to overcome the core lack of a sense of having a safe 'maternal base' as a result of inappropriate mothering during early childhood. Furthermore the mother is responsible for her daughter's development of anorexia as a result of her inability to allow a process of separation and her fear of her daughter's sexuality. Schaverien clearly situates blame for the development of anorexia on the role of the mother.

The connection between borderline personality and anorexia is not unique to Schaverien. Johnson and Connors (1987) proposed that patients with anorexia and bulimia are divided into "borderline" and "false self" subtypes which resulted from an underpinning concept of pathogenic mothering. In relation to the false self and mother's blame, Orbach (1993), a cofounder of the women's therapy centre in London draws on Winnicott's (1965) concept of true and false self and suggests that the bodily experience of the girl comes from early relationship with her mother. The girl senses her body as a "false body" (Orbach, 1993) that results from finding her self with "a body that feels wrong" (p.169). Although Orbach (1993) describes a connection to the early relationship of the mother and child she provides the following socio-cultural explanation: "in raising a daughter a mother will be inclined to shape her physical development in line with accepted social practices" (p.170). Thus even if an early connection is made to the mother within the context of psychodynamic theory, the mother can be seen as contextualized and as a result of socio-cultural discourse. Schaverien (1994a) avoids the socio-cultural contextualization of the mother and uses psychodynamic theory without qualification.

Schaverien's (1994a) understanding of anorexia nervosa positions food as "a means for expressing something else" (p.52). In this sense food is a symptom and an object that fulfils a role within the internal world of the patient. Schaverien (1992, 1994a 1994b) directly develops this understanding through her discussions of the concept of a transactional object. As stated by Schaverien (1994a) "The word transaction implies a category where the object is used in exchange for something else. It is an object through which negotiation takes place. This may be thought to imply a conscious transaction but the process to which I refer is primarily unconscious and may be magically invested" (1994a, p.50). For Schaverien the transactional object embodies unconscious content but is a physical object in the world. As such manipulation within the real world of this embodied object involves the additional internal manipulation of its unconscious content. In this sense the transactional object can be a component in a negotiation of internal meaning. According to Schaverien, for the girl who

has anorexia food is considered to be a transactional object. Within the art therapy process, the art work can also be a transactional object offering the art therapist a means for interacting with the patient's internal world. In Schaverien's theory of art therapy, the role of the art object is also explained in relation to what she terms as scapegoat transaction. As stated by Schaverien (1994a) "The pictures, once embodied as scapegoats, may subsequently become empowered. Such objects may be regarded as talismans in the therapeutic relationship because they are experienced as carriers or containers of magical significance. This initial identification with the art works may lead through a series of pictures, to separation, symbolization and the ability to talk about the experience. Thus a conscious attitude develops to the previously unconscious material" (p.48). This is an important theoretical position that justifies the use of art and the artistic object within the therapeutic process.

In addressing the treatment of anorexia nervosa, Schaverien (1992, 1994a, 1994b) bases her therapeutic understanding on the concept of both food and art as having the potential to be transactional objects. As stated by Schaverien (1994a) "Like food, art materials have a physical presence and, like the mother offering the child food, the art psychotherapist provides art materials for the patient to use. The concrete nature of this transaction, within the therapeutic boundary, sets up a resonance with the problem. This can be observed in the use made of the materials; often they are used in a similar way to food." (p. 50). In this quote, Schaverien creates an equation in which the art object equals food and the therapist equals the mother. Schaverien presents a situation in which the problematic mother-child-food relationship is recreated within the art therapy setting. Therapy in this context involves the movement of the problem between mother and daughter expressed through the patient's control of food intake to the therapeutic setting of art therapy. In this formulation, the art therapist replaces the mother and through her informed interaction with the anorexic girl and her art work can therapeutically negotiate a change in the girl's developmental problem with her mother. Scheverien's position here is predicated on the assignment of blame for anorexia on the mother of the girl who has anorexia and proposes that the art therapist essentially replace the relationship with a 'bad' mother with that of a 'good' mother.

In her 1994a paper, Schaverien presents an art work that in her words "shows how the pictures begin to reveal and embody the inner world of the patient" (p.52). Figure 7.4 is described by Schaverien as consisting of a "slim fairy figure which floats above temptation, high in the sky, could be understood as in flight from reality" (p.52). She goes on to say that

the "female figure is suspended, neither child nor woman" (p.52). Schaverien considers this type of painting to be a "very common type of picture for anorexic patients" (p.52). Schaverien (1994a) describes this painting as "decorative" and that the picture was seen by the artist-patient as "no more than it appeared an attractive image drawn in coloured felt tip pens". This patient's response to her painting is defined by Schaverien as "defensive and protective" and "unconnected to her feeling self" (p.52). In a second session, Schaverien describes a picture that was drawn on the back of the first picture. Figure 7.4 is described by Schaverien as "a very small pencil drawing of a girl curled up in an oval shape, reminiscent of an egg" (p.58). Schaverien (1994a) states that this image revealed how "withdrawn, little and regressed" (p.58) the artist-patient felt.

In her analysis, Schaverien underplays the role of the first picture seeing the second picture as the point at which emotional embodiment takes place. The first picture "was not a transactional object in any embodied sense. In contrast the tiny pencil drawing on the back of this 'pretty picture' was the start of engagement in art psychotherapy" (Schaverien 1994a p.53-4). The first picture is alternately termed "pretty", "decorative" and "attractive". Schaverien positions this picture as divorced from the artist-patient's feelings and an attempt to affirm to the therapist that "all is well" (p.52). From a feminist perspective the issue of female attractiveness is a significant one. Attractiveness is one of the stereotypical gender roles and is problematic. As argued by Bartky (1990) in a phenomenological analysis of male domination, the need for women to be attractive is based on the importance of the physical body in gaining acceptance from men. As analysed by Bartky (1990) women are oppressed through their need to constantly receive recognition from men. This patronage is based on physical attractiveness. Accordingly to be attractive is a core requirement that directs an extensive system of bodily rituals and modifications described by Gimlin (2002) as a system of body works. What Schaverien avoids is the gendered, oppressive nature of attractiveness in patriarchal society.

In addition, there are a series of sexual assumptions associated with the idea of young women being pretty, decorative and attractive. The young woman depicted in the picture seems to be wearing a swimsuit or underwear. Her body is exposed. She is the centre of focus and attention. Rather than an 'escape from reality' as interpreted by Schaverien, the picture would seem to depict a discursive reality of how young women are supposed to be seen (including the affirmation that everything is well). Wooley's (1994) perspective as a male therapist working with eating disorders is interesting here when he claims that the male gaze promotes the need for young woman to be thin. As found in Bordo (1993), Wooley (1994) is

using thinness as a synonym for attractiveness. This male gaze is inherently sexual and involves "access to women's bodies" as "the prize of dominance" (Wooley, 1994, p.18). Women's sexuality, attractiveness and thinness are all influenced by the presence and dangers inherent in this male gaze. Anorexic girls constantly evaluate themselves against the impossible ideal size that determined their self value, status, success, social recognition and acceptance, and it is never good enough (Hoskins, 2002). Anorexic girls have internalized the male gaze which ties physical attractiveness of a particular type (thinness) with social worth.

Schaverien's application of theory directs her to consider early mothering as a cause of anorexia and to belittle the inherent presence of gender roles and their associations in this first picture. Schaverien seems to be ignoring the issues of gender that are part of this girl's discursive reality. The second picture is also interpreted in terms of object relations with the ideas that the girl has 'regressed" to an earlier state. However the picture is very reminiscent of images found within Luzatto's (1994) corpus. The girl in this picture seems vulnerable hiding her body under her long hair. She seems to be threatened by some outside force (unmentioned by Schaverien) depicted as a squiggle outside the egg shape. The enclosing shape seems to be protective more than representative of a regressive state. In relation to the gender role of attractiveness it is possible that the image provides some insight into the need of this girl to be protected. In a world ruled by male gaze, attractiveness brings with it fears of being attacked and hence some form of protection may be needed. A different aspect of the need for protection finds its source in the analysis of the role of the medical institute itself. As argued by Bell (2006) hospitalization is an intrusive and controlling experience that is designed in the case of anorexia to increase body weight, often interpreted by the hospitalized girls' discursively fixed with the male gaze as a loss of status, attractiveness and value. Hospitalization threatens to take a way from the young woman her thinness and this loss brings with it the perception of loss of her social success, status and her sense of self worth.

Schaverien's theory of anorexia nervosa and its treatment is heavily influenced by object relation theories of early development. This theoretical orientation brings with it gender positions that place blame on mothers and her early mothering skills. Anorexia is situated within the individual girl patient and her distorted view of food and her body. Her theory of art therapy treatment for anorexia nervosa involves the replacement of the 'bad mother' with the therapist positioning the mother not only as the source of the disorder but also as replaceable. Schaverien's conceptualization of anorexia nervosa based on concepts of pathological mothering ignore the socio-cultural and discursive aspects of eating disorders and damages the mother-daughter relationship. Schaverien's presented analysis ignores the

discursive gender role of the artist-patient and focuses instead on the exemplification of Schaverien's theory of art therapy and anorexia. Her theory of anorexia and its treatment presents an accusatory set of positions concerning women and avoids the social discursive framework within which women are constructed. The role of men and fathers is ignored by Schaverien. As stated by Ruskay-Rabinor (1994) "Clinical formulations and interventions that aim to understand and 'fix' mothers while ignoring fathers are implicitly mother blaming" (p.274). Ruskay-Rabinor (1994) further quotes Miller (1976) who states that "it is easier to blame mother than to comprehend the entire system that has restricted women" (p.275). As seen in previous analyses of anorexic art within the discipline of art therapy, psychological theory overrides expressed experience and brings with it a series of predefined gender positions that minimize the understanding of discursive and cultural factors.

Figure 7.4 Pictures addressed by Schaverien's (1994a) Analysis of Art.

7.4.6 Mary Levens (1995)

Mary Levens is an art therapist and psychodrama psychotherapist working in the British context. In her 1995 book, entitled "*Eating Disorder and Magical Control of the Body*", she presents an extensive, psychoanalytically informed explanation of the phenomenon of patients with eating disorder. Her theory derives from her observations of a "recurring theme either in the content of paintings made by patients or through associations with their artwork" (Levens, 1995, p.iv) made during her work as an art therapist within an in-patient eating disorders unit. This recurring theme in art work of girls with anorexia is connected by Levens to Freudian understandings of the psychic role of cannibalism. As with other psychodynamic theories, Levens (1995) situates the source of anorexia nervosa within developmental processes and directly blames early mothering. As stated by Levens (1995) "The anorectic is seen to have unresolved problems in the oral incorporative stage, which have impeded the process of separation and individuation. The anorectic fantasizes the oral incorporation of a bad, over controlling maternal object, which is then equated with her own

body. Self-starvation is often viewed as the adolescent's attempt to end the feminization of her body and to minimize the confused and ambivalent identification with her mother" (p.59-69). Within this explanation of anorexia, self starvation the main behavioural characteristic of anorexia nervosa is a way of resolving cannibalistic fantasies relating to her mother.

As explained by Levens (1995) the link between early mothering and cannibalism is related to problems with the development of an individuated self following breast feeding. During breast feeding the child and mother are experienced as one entity with the mother being eaten. However, eventually the baby recognizes that it is the mother who has the food and not the child herself. This situation creates what Levens (1995) terms "an intolerable realization that it is the mother who posses what the baby needs" (p.50). This realization evolves within the baby as a sense of envy and the desire to fuse with the mother. Using Freudian and Kleinian concepts, Levens (1995) connects this envy for fusion with the mother as a cannibalistic desire, the desire to eat and thus own her mother. This cannibalistic fantasy leads to problematic perceptions of body boundaries and confusion over closeness and intimacy. In this situation, closeness cannot be differentiated from the "threat of being swallowed up by the other person or being overwhelmed by their own devouring wishes" (Levens, 1995, p.52). A person without a developed and separate sense of self is consistently fearful of being totally engulfed by others. As stated by Levens (1995) "The reality for the patient with an eating disorder who is functioning at this level is that she fears that whatever has to be done in order to save her identity will involve her in destroying the very object which she feels she depends on for her survival. She must face the horror of her own cannibalistic wishes, especially as they are directed towards the very people whom she loves" (p.55).

Levens (1995) specifies a series of recurring images and themes that appear within the art of patients with anorexia. She chose several pictures that present cannibalistic imagery that support her theory of psychic cannibalism as the underpinning cause of anorexia nervosa. The pictures presented in Figure 7.5 have central images of bodies and faces being eaten. Levens (1995) explains these pictures as representations of severe difficulties with closeness in which the patient cannot perceive of a situation in which two separate people exist and thus one has to be devoured. For Levens (1995) cannibalistic imagery for eating disordered patients also represents problems with boundaries. As stated by Levens (1995) "boundaries are needed not only to define themselves but also to keep others out" (p.69). Within the artwork these boundaries can be created through the use of words or the reinforcement of the painting surface as well as through the representation of a loss of boundaries between the

inner and outer world. This issue with boundaries can be represented through imagery of leaking objects such as "vaginas, fabric or leaking roofs" (p.74). This type of imagery is explained by Levens (1995) as relating to the patient's fear of the destruction of her body boundaries. In a related set of images, the opposing pole of experience is expressed. Rather than images of leaking objects, representations of "locked doors, high walls or closed curtains" are presented signifying according to Levens (1995) a desire for separation and that the therapist should "keep out". In addition, as seen in Figure 7.5 Levens (1995) notes that within the art of patients with anorexia there are frequent representations of "wombs, or containers of some sort" (p.73). Once again, these types of representation can be seen as addressing the core problem of boundaries within the anorectic patient. Finally, Levens (1995) points out that the patients demonstrate "radical 'single-mindedness'" in their use of materials, in the "colouring of the theme and in the black and white evaluation of their work (that is, the work is either wholly good or bad)" (p.100). These characteristics are understood by Levens as an inability on the part of the eating disordered patient to contain ambivalent feelings.

Levens (1995) considers art therapy to be particularly suited for the treatment of eating disordered patients. Her position is based on two different aspects of art therapy. First, art is a non-verbal form of communication and as such it may "bypass the defenses of patients with eating disorders" (Levens, 1995, p.103). In addition, the creation of art can be seen as enhancing the patient's opportunities for separation. As stated by Levens (1995) "I suggest that the involvement of the patient in the creation of artwork, using concrete, durable imagery, in the presence of a facilitating therapist may be regarded as an important step towards the development of a whole-person relationship" (p.102). Within the therapeutic relationship, the art therapist should create a situation in which the patient can experience a relationship that is close but is not either "all-consuming" or "totally abandoning" (p.100). In this sense the therapist corrects the problems of separation and individuation created through problematic early mothering. Levens (1995) further specifies that the anorectic's battle with her own body as a "concrete representation of the unacceptable part of herself (passive receptiveness) and, second the territory or base of an all powerful, alien invader" will be present within the art therapy process. Accordingly it is important for the art therapist that the battle over who owns the body and the nature of a relationship as life enhancing rather than annihilating, be "worked through" in the therapeutic process. The therapist within the art therapy process functions as a corrective mother replacing original mothering experiences.

As with previous psychoanalytical analyses of anorexia nervosa, Levens (1995) ignores the role of social context in the development of self starving women. The underpinning psychodynamic theory directs the whole of Levens (1995) explanation towards experiences in early childhood and particularly the early mothering of the girl with anorexia. As seen in previous analyses this is an accusatory narrative that sees the mother as responsible for the development of anorexia and the girl as deeply flawed. The attack against the mother does not end with an accusation but is continued into the therapeutic setting with the art therapist situated as a surrogate mother who can reverse or at least moderate the damage created by the problems of early mothering.

A special aspect of Levens (1995) theory is her development of the Freudian concept of psychic cannibalism as the core issue in anorexia nervosa. The idea of the girl with anorexia as suffering from psychic cannibalism has specific ramifications on the construction of women. Actually Levens (1995) references some of these stereotypical positions in relation to women by addressing some mythological and anthropological references. As well known and stated by Levens (1995), cannibalism is linked to greed and devouring mother myths such as the witch in Hansel and Gretel and the 'she-monster' Scylla. The Freudian theory of cannibalism once applied to the situation of girls who suffer from anorexia, goes beyond the idea that these girls are deeply flawed and presents these girls as borderline, inhuman monsters. This particularly destructive narrative of the construction of women has misogynous overtones and seems to represent a deep rooted cultural fear of women as the bearers of life and death. . What is interesting is the actual pictorial and verbal data that is presented as supporting this narrative. The data consists of images of women being devoured, problems with boundaries, and the presentation of images of containers and walls. Clearly, these girls feel threatened and in need of protective walls. Specifically in this data set they seem to be scared of being attacked and annihilated. The last picture in Figure 7.5 is explained by Levens (1995) as an image in which the girl "ensures that nothing or no one can penetrate her brittle barrier, and fearing that she will be totally wiped out if she lets things or people into her" (p.36). The picture itself presents a body literally attacked by a series of hands touching different parts of her body. Two hands seem to be strangling her and her mouth is shaped into a scream. Rather than a fear of her own cannibalistic fantasies this picture suggests a much greater fear of physical and sexual attack. Levens (1995) theory is destructive towards the definition of women and ignores basic fears that women may face growing up in patriarchal devouring society. As in previous cases, Levens (1995) use of

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psychoanalytical theory erases the expressed experience of these girls and leads to accusatory and particularly negative visions of women.

Figure 7.5 Pictures addressed in Levens's (1995) analysis of Art

7.3.7. David Maclagan (1998)

David Maclagan is a male art therapist working in the British context. His 1989 paper presents a case study of his art therapy treatment of a young female patient with anorexia nervosa that included in and out patient care as well as private sessions over a period of about five years. At the beginning of his chapter Maclagan (1989) states "I have deliberately chosen not to present a conventional case study, with its circumstantial details because I believe that her imagery can be understood against a wider and deeper background" (p.79). He then goes on to state that he is going to "follow the links between the consulting-room and the cultural world in which it is located, and to allow the clinical to open out into the imaginal" (Maclagan, 1989, p.79). Initially, Maclagan positions his analysis and the patient's art work against a broad cultural and spiritual context. He considers the patient's struggle with her body to rehearse "certain metaphysical conflicts that have a long standing and peculiarly intense place in our culture" (Maclagan, 1989, p.79). Specifically he sees these metaphysical conflicts as "oppositions between spirit and matter, purity and muck, masculine and feminine, independence and dependence, and life and death" with the girl suffering from anorexia living in a "no-man's land: on the edge between pre-pubertal and adult sexualities, between maternal and patriarchal authorities" (Maclagan, 1989, p.79). According to Maclagan (1989), these girls "delight in taking things to extremes" and have difficulty in modifying these conflicts towards some "middle ground" (p.79).

This movement towards extremes characteristic of girls with anorexia is explained by Maclagan through his development of the concept of the negative sublime. Maclagan explains this term as a "demanding image of impossible perfection whose influence on ordinary life is corrosive and potentially lethal" (Maclagan, 1989, p.81). For these girls perception of the world is dictated by the 'anorexic sublime' that demands perfection in all its

endeavors, including the physical aesthetic. This is an issue of extreme control directed by a "perfectionist and idealized aesthetic" (Maclagan, 1989, p.81). This idealized perception of the world stands in contrast to the real material world of existence and thus directs extreme responses from the girl with anorexia trapped within the confines of this ideal. Within this psycho-social construct, the media presentations of immaculate "cosmetic women" which contradict the "messy reality of menstruation" and the "irregularities of physical imperfections" (Maclagan, 1989, p.84) can be seen as particularly pertinent.

A core element of Maclagan's theory is the proposition of a cultural explanation of anorexia nervosa that addresses the relationship between anorexia and a gendered, consumer society presented in fashion and the media. Maclagan (1989) states "anorexic starvation can be seen both as a reaction against the display of conspicuous consumption and as a secret collusion with the spectre of poverty and emptiness that haunts it" (p.83). In this sense, anorexia is an embodiment of the conflicts and contradictions which exist on a broader cultural level and acts as a "condenser of dilemmas or crises that haunt our culture" (Maclagan, 1998, p.89). This cultural crisis consists of the inherent contradictions of consumer imagery that presents "images of luxury" and "indulgence" but are directed through the presentation of women with "waif-like deprivation" (Maclagan, 1998, p.83). These images bring with them a degradation of women. As stated by Maclagan (1998), these images conflict the ideal with the real and promote "femininity not only with attractiveness, but with passivity" and "self-abnegation" (p.84).

In relation to the negative sublime, anorexia is positioned as a "rebellion against the compromises and ambiguities of incarnation, with the muddle in the middle" (Maclagan, 1989, p.86). Anorexia involves the inability to compromise the contradictions of the ideal and the real and results from a choice of the ideal and the impossible. The choice is for a "rigorous editing of the body, in the name of a transcendence of material imperfection" (Maclagan, 1998, p.85). According to Maclagan (1998) the ambition of the anorexic is to "escape the body with its organic untidiness" and move towards a "clarified, frictionless and weightless" discarnate mode of being. This is similar to Gimlin's (1994) explanation of anorexia resulting from an over conformist acceptance of the contradictions that are inherent in the socially promoted role of women.

The art work presented by Maclagan (1998) is described as consisting of "many images of cleaned-out, empty containers (bowls, acorn-cups, shapes almost like the inside of hollowed, emptied breasts): these were the holders of immaculate emptiness" (p.85). These images are characterized, according to Maclagan by their "purified perfectionism" (p.86). In

one of the pictures analysed by Maclagan (see Figure 7.6) a bird whose body is a hollow bowl is depicted. Maclagan (1998) describes this picture as a depiction of a "sublime ambition" that "has quite lost touch with any ordinary world" (p.87). This is related to anorexia by Maclagan (1998) through the statement that the effect of starvation "ends up insulating the fasting person from any contact with reality and hooks them into a sublimatory spiral of metaphysical aspiration in which they become increasingly ungrounded" (p.90).

In his analysis of Figure 7.6, Maclagan sees "sublime ambition" and a movement away from reality. What he does not see is the vulnerability of the bird presented through the openness of its body and the arrow, defensive nature of the bird's body, pointed wings and beak. As we can see from the artistic composition, this bird is presented within a very confined environment. The bird seems trapped within this environment. The poem written by the patient about her picture uses the following aggressive imagery: "Forcing a path"; "Piercing a cloud"; and "saber beak" (Maclagan, 1998). The bird is an aggressive image that results from the vulnerability of the way the bird is presented. This bird feels attacked (perhaps since her body is open) and accordingly needs to defend herself. The picture can be understood as a statement of this patients fear. The open areas of the body need to be protected from potential external invasion.

As Maclagan rightly states his analysis of anorexia nervosa is a cultural and spiritual analysis rather than a feminist analysis of anorexia nervosa. His critique is directed against the problems inherent in consumer society and the influence this has on consumers. He recognizes that women in general, and those women who suffer from anorexia nervosa in particular, suffer from the construction of women within this consumer society. However, Maclagan does not really enter into a much deeper analysis of the way female gender is constructed in a patriarchal society and the fears and dangers that might be inherent in this identity. It is important to note that in the list of metaphysical contradictions embedded within consumer society presented by Maclagan (1998), two gendered, dichotomous concept collections are created: spirit-purity-masculine-independence-life and matter-muck-feminine-dependence-death. In his analysis Maclagan states that the girl with anorexia chooses the "negative sublime" a choice for the ideal and the first, 'masculine' set of concepts. What Maclagan does not state is that the other option, the feminine concept collection, is inherently negative and nearly impossible to choose. This aspect of the misogynist construction of women creeps into Maclagan's analysis and plays an unrecognized and unanalyzed role in his theory. Ultimately Maclagan (1998) sees the problem of anorexia as the "difficulty in accepting incarnation, the capacity to live with or inhabit the body and its untidy processes,

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rather than subjecting it to persecutory control or mortifying metaphysical ambition" (p.88). He focuses on the desire for the sublime; but does not pay attention that this is also a rejection of being a woman as a result of the deep cultural, negative construction of what a woman is.

Underpinning Maclagan's (1998) theory is what Malson (1998) discusses under the heading of Christian asceticism and as an aspect of Cartesian dualism. His critique of consumer society comes from a Christian moral stance that consumerism, like fat is morally bad. Cartesian dualism in the Christian ascetic divides the mind/spirit from the body with the indication that the body needs to be overcome in favour of spirit. As argued by Malson (1998) the consideration of fat as immoral comes from the Christian theme of the "renunciation of the flesh" (p.131). This conceptualization of the world that is embedded in a variety of cultural practices directs a complete denial of the significance of the material body and may construct a "cultural norm" that makes many women feel "hatred" towards their bodies (Malson, 1998, p.132). As argued by Malson (1998) this deep aspect of cultural construction is particularly prevalent within consumer based society and is directed towards the construction of women. Malson (1998) states that constructions of "fat as morally bad, and of weight reduction as a quasi-spiritual struggle against the body, are also evident in the jingoistic phrases used by the dietary industry such as 'fight the flab', 'burning off' calories or fat, and 'fatbuster' diets (see Bordo, 1990) and in the widespread moral condemnation of fat as a signifier of lack of personal control" (p.132). In other words, women to a large extent are the target of current uses of this deep cultural theme of the renunciation of the flesh as this continues the cultural construction of women as lacking control and essentially "of the flesh." As argued by Hogan (1997) "woman have been represented in our culture as ruled by our bodies and sexuality, and as seen as corrupted and corrupting, sexual, lascivious, sly, untrustworthy and a danger to moral and social order of society" (p.18). It is this cultural contextualization within religious and cultural discourse in addition to consumer society that interacts in the construction of women and that influences the understanding of anorexic girls.

Figure 7.6 The "Ornamental Blue Bird" Addressed in Maclagan's (1998) Analysis

7.4.8 Susan R. Makin (2000)

Makin is an expressive arts therapist working within the Canadian context. She presents an analysis of art therapy with girls who suffer from anorexia in a book that summarizes her work within a hospital setting. Makin (2000) starts her description of anorexia nervosa with a medical discussion including the usage of the diagnostic definition presented in the DSM-IV and a list of physical conditions that are related to anorexia nervosa. In relation to the psychological explanations of anorexia nervosa, Makin (2000) states that "it is generally believed that problems arise because of a psychological disturbance involving feelings of poor self esteem, helplessness and ineffectiveness" (p.24). This statement is characteristic of Makin's (2000) approach to the description of anorexia nervosa that focuses on the feelings embedded within the art work and ways these are manifest in the art therapy process. Makin (2000) states that in her experience "whatever is depicted in one medium can easily be translated to another; whatever and however someone is feeling will come up over and again in whichever medium they are working until they are ready to move on from it" (p.123). In her analysis of the art of patients with anorexia, Makin (2000) specifies that the themes of "loneliness, isolation, death, hopelessness and suicidal ideation" (p.114) arise within the art work of her patients. In addition, Makin (2000) specifies that "tombstones, food, cages, traps, devils, pets, objects of abuse, toys, perfect and unpleasant settings, intricate doodle designs, masks, isolated individuals and mothers" (p.114) are often depicted within this corpus of art produced by patient's with anorexia.

Makin (2000) sees a clear therapeutic role for art therapy in treating anorexia and describes this process in the following way "Initially they are tightly bound up in their eating disorders and related thinking, but by the time their treatment is reaching its conclusion the changes in both imagery and thoughts associated with it are drastically different" (p.121). She provides a developmental art therapy based model of the treatment of patients with anorexia. According to Makin (2000) there are three stages of art therapy treatment for patients with anorexia. During the first stage they use "pencils, fine markers and pencil crayons", have a "tight, faint, constrained" style and address the themes and symbols of "solitary people, absence of colour, unpleasant or very pretty" (p.124) content. During the second stage they "experiment with messier materials such as finger paints and clay", have a "larger" and "looser" style that addresses "more of the page", and the themes have "more diversity and less gloom" (p.124). During the last stage of therapy, they are "more process orientated" than "product-orientated", are able to "make mistakes and mess" and address themes of "integration and recovery" (p.124). Fleming (1989) also produced a developmental model of

the stages of art therapy treatment of girls with anorexia that moved from 'hard' materials that give a sense of control to more 'fluid' materials like gouache that are more free flowing and their usage indicates a change in the position of the patient.

Makin (2000) presents 50 pictures of art made by girls with anorexia within her book. Many of these pictures exemplify the art therapy methods she uses with her patients. But she does specify a limited number of "telling images" that "reflect universal feelings" (p.120) and are representative of her understanding of anorexia. In her discussion of a plasticine clay and paper plate art work entitled 'Body Trap. Will There Ever Be an Escape?' (see Figure 7.7), Makin (2000) describes the art work as depicting "her body is in the centre, chained and helpless, and a snake extends towards her over the red edging of the circle in which she is trapped" (p.122). In the second picture that Makin chooses as representative of the images of anorexia nervosa, she presents a picture from the end of treatment (see Figure 7.7). Makin (2000) describes the content of this picture as "the 'moody gardens' that need to be tended for recovery. By means of a watering can's sprinkles, she is able to review all the elements involved in getting her to this stage of recovery: discovery, independence, friendship, family, esteem, reaching out, emotions, 'nineteen weeks' (the length of her admission), truth, new opportunities and 'why weight?' (the eternal question that needs to be kept in perspective)" (p.122). The third and last picture presented as representative of anorexia nervosa was chosen from one of the early paintings of a patient (see Figure 7.7). The picture is of a magic wand and it is from one of her patient's creative journals. In describing this painting, Makin (2000) quotes from the artist-patient's writing where she states "Lost: one magic wand. How do you heal from 30 some odd years of abuse? Still searching and still my heart cries" (p.123).

In Makin's (2000) presentation of anorexia nervosa, the art works and art therapy process are understood as embodiments of feelings. As seen in Makin's choice of representative art works, her sense of the experience of anorexia nervosa is one of suffering and entrapment. This is seen in both the pictures presented in this section and in descriptions of anorexia spread throughout the book. At one point, Makin (2000) quotes a journal entry from a patient entitled "The Freak'. In this journal entry the patient expresses feelings of being "disgusting and ugly", fear of being judged and of being a "creature" with "Bucky Beaver teeth and piglet nose" (p.115). This journal entry also includes expressions of self anger and the desire to hurt herself. As presented by Makin (2000) the experience of these patients with anorexia involves anguish and self torment. Makin (2000) does not obscure these feelings and experiences through the application of psychodynamic theory and explicitly avoids assigning any form of blame to the patient or her family. However Makin

also does not explore the situated, social and discursive nature of the experiences presented by her patients or directly address issues of gender. From a feminist perspective the feelings and experiences expressed by the patient-artists could be explored in relation to the images and roles of women in the world and the way the enforcement of these discursive positions situate women and generate the negative feelings that are expressed. Her approach is one of containing feelings and not one that is designed to negotiate their experiences and actively empower women. The feminist art therapist Lupton (1997) points out that art therapy directed at emotional self expression "tends not to challenge the broader social and cultural conditions in which the individual finds herself constructed as other" (p.1). Lupton (1997) further specifies that art therapy can be "overtly political, in which art is used to express and critique the socio-cultural context in which pain, illness, disability or social stigmatization or inequality are experienced" (p.1). For example, in Figure 7.7 this art work could be seen as representing fear of sexual assault with a tied female figure helpless and incapable of protecting herself. The social ramifications and gender definitions that this involves are ignored by Makin. The presentation of anorexia nervosa is left on the level of the discussion of these feelings and changes in the ways of art making. Paradoxically, an uncritical acceptance of these feelings without social and cultural contextualization may actually enhance (rather than decrease or deflect) feelings of worthlessness. Makin's (2000) approach situates anorexia nervosa within the individual patient and in relation to her expressed feelings. Therapy involves addressing, controlling and changing some of these feelings through visual art and other expressive modalities.

7.7 "Body Trap", "Moody Garden" and "Magic Wand" Pictures Addressed in Makin's (2000) Analysis

7.4.9 Mury Rabin (2003)

Rabin is a registered art therapist working within the American context. Referencing clinical evidence from Hatterer (1980), Rabin (2003) initially presents anorexia nervosa as a form of addiction. She sees anorexia nervosa and bulimia as two poles of the same underlying

problem. As stated by Rabin (2003) "the two disorders touch, as the eating cycles of each mimic each other in the classic yo-yo syndrome. The anorectic has periods of starving and bingeing as the obese has periods of gorging and dieting" (p.9). Rabin (2003) uses Bruch (1973) to define the underlying problem of eating disorder as a "distortion in body image" (p.9). Rabin quotes Bruch's (1973) statement that "A realistic body image concept is a precondition for recovery in anorexia nervosa" (p.90).

Rabin (2003) states that in her experience the underlying problem is one of "self-concept" (p10) and the connection between the "body image" and "self" (p.11). As stated by Rabin (2003) "Both anorectic and obese people demonstrate body image distortion. Each may never have developed the sense of the self or may have lost the ability to know his self-concept" (p.12). Rabin (2003) states that "Accurate body image is necessary for the total and independent functioning of the individual" (p.13) and that "the body image or the body identity is the conceptualization of the body's structure and functions that grow out of the awareness of the Self and one's body in action" (p.13). She further states that "where the self-concept is unavailable the individual is confused about her body image" (p.14)

As presented by Rabin (2003), the development of body image is influenced by both developmental and cultural forces. Rabin (2003) states that "It is evident that early experiences play a role in the healthy development of all individuals. It is no less so for those who are at risk for the advent of addiction. Families attitudes about food and eating impact on the ability of those at risk to develop appropriate patterns of behaviour associated with the body and its image" (p.152). Rabin (2003) further explains that "If a person experiences himself during childhood within his family in a certain role – labelled by father, mother, siblings as fat or stupid or "less" than another – he cannot come to the present, perhaps when he has lost weight and actually looks different – genetic shape restored , etc, because his perceptual apparatus becomes forever enslaved through experiences and "knowing": we cannot help distorting our perceptions given our knowledge… …Experience places an obscuring veil of understanding between us and the world" (p.152). Rabin (2003) also addresses what she calls the development of a "unique individual" within the family. As stated by Rabin (2003) "If the child experiences herself as a function of a member of the family rather than as a unique individual who is accepted and welcomed into the family group, stagnating behaviors may be triggered" (p.153).

On a cultural level, Rabin (2003) specifies the role of peer experiences within the university setting and the role of media in the development of anorexia nervosa. Rabin (2003) states that "Information about the rituals of fasting, limited intake of food, use of some

laxatives, and self-purging became widespread. First-year college coeds (especially in women's colleges) were inducted into these practices by older students, like entering into a secret sorority. Anorexia became rampant on campuses" (p.8).

Another aspect of Rabin's (2003) position is a concern for the need to address male eating disorders. She feels that the emphasis on women has obscured those male patients who suffer from this disorder. It is within this context that she enters into a discussion of feminism and the Jungian concepts of anima and animus. Rabin (2003) presents feminist thinking as a cultural force that has changed perceptions of male and female categories. Rabin (2003) states that the "old boundaries of gender stereotypes were altered" and that the "feminist movement became a force that touched the very essence of women and men, stirring male and female qualities within each individual" (p.16). The changing definitions of male and female has according to Rabin (2003) led to the situation in which both "men and women are confused about the messages received from a culture that is in transition" and that this "state of the culture has influenced the trend to homogenize men and women" (p.21). Rabin (2003) comments on this situation by stating that the feminist movement in the US did not "resolve the inner conflicts that were aroused in both sexes" and that unless "there is inner reconciliation to balance all the factors in one's life, male and female, the individual will continue to struggle" (p.17). In Jungian terms, Rabin (2003) states that the "search for the Self requires the opposing psychological forces within to establish a balance between the push and pull of the anima and animus" (p.17). In relation to anorexia nervosa, Rabin (2003) sees the loss of weight as a movement towards a "more masculine aspect" and that "exaggeration of the natural appearance of the gendered form destabilizes the boundaries of the body dimension and results in an amorphic body image" (p.17). As stated by Rabin (2003) this "manipulation of the physical body boundaries challenges the genetic template of the human form, creating a struggle to reestablish its gestalt" (p.17).

Treatment within Rabin's (2003) context is based on the idea that connections between the body image and self need to be reestablished for treatment to move forward. As stated by Rabin (2003) "where body image connection is impaired or distorted it is necessary to restore and repair body dimension concept as a prerequisite to treatment of the symptom" (p.13). Rabin's (2003) concept of treatment utilizes a wide battery of psychological and art therapy based tools. The core idea directing her therapeutic work is to direct the patient to "make appropriate connections from the body dimension to the body image" and finally "forming a symbol of herself based on truth" that "lays the groundwork for a positive self-concept" (p. 157-8). As stated by Rabin (2003) it "is necessary for the patient with a

disturbed body image to retrace, actually and symbolically, the history of her self-concept and be allowed to regress in order to repattern her sensory perceptions to retrieve her lost body dimension" (p.158).

Rabin (2003) presents five case studies using her approach to the treatment of eating disorders. In her summary of one of the case studies, she states as the patient "progressed in therapy, her physical appearance altered. She had several haircuts during the course of the project, changing each time to a more sophisticated look. The clothing she wore in the later sessions was more attractive and feminine, switching pants to dresses. Her earrings matched and her eye makeup softened, resulting in a more integrated and harmonious appearance" (p.72). The movement towards a more feminine appearance is a central theme of all of her treatment outcomes. From one patient Rabin (2003) quotes "I have a number of image problems to work out" and that she was "afraid of further losing her feminine identity"; but as a result of therapy she can now "hold her sexual identity constant" (pp. 66-7).

Rabin (2003) presents 18 pictures within her book. The pictures are all situated within her presentation of five case studies and all result from an extensive series of diagnostic tests and procedures that she used within her treatment. Nine of the pictures (50%) consist of pencil female figures drawn at the beginning and ending of treatment. The difference between these two pictures is of special importance to Rabin as she sees the changes in the drawing of self as a female figure as a major sign of treatment success. In relation to Figure 7.8, Rabin (2003) states that in the end of treatment picture "we can see her emerging sense of femininity and sexuality" and as a "mature, attractive woman close to her own age" (p.72). As can be seen in the picture, the differences between the first and second drawing consist of an emphasis of female breasts, a more stylish hairstyle, a change in clothes from trousers to a skirt, and the positioning of crossed hands and legs covering her crotch. The second picture represents a stereotypical presentation of what a women looks like. It would seem that successful treatment in this framework is the movement towards this stereotypical gendered presentation of self.

This picture emphasizes the nature of Rabin's theory of anorexia nervosa and her approach to art therapy treatment. Her theory is infused with a normative concept of gender. This socially constructed concept of women and images of women delimits the boundaries of what a woman is and what a woman can look like and directly pathologizes any other ways women may present themselves. Rabin's (2003) own perception of what a woman should look like is the basis for her evaluation of a positive outcome for treatment and is the measure of success. As seen in the quotations presented above, Rabin (2003) sees her own social

constructed gender images as genetically defined and as natural. From a feminist perspective this position is problematic but it is interesting to note that the difference between the before and after treatment pictures of this particular patient are not different in relation to the size of the body image. It is the external stereotypical feminine characteristics such as clothing and hair that actually have changed and Rabin is responding to and not any genetic definition of body type. Rabin (2003) regresses to a genetic definition of gendered body image to negate the presence and role of the social construction of gender. She follows a patriarchal rhetoric described by Hogan (2003) in the following terms "*biological arguments about 'natural' difference have been used to justify particular gendered practices and conventions (which often incorporate aspects of inequality and oppression)*" (p.12 italics in the original). Rabin's (2003) stated position differentiates gender into fixed categories of male and female that are outwardly defined by genetics and include specific sexual roles. Her assurance in the rightness of her gender positions (including her argument that feminism is problematic because it confused gender roles and that anorexia is a movement towards being masculine) gives her the authority to direct the treatment of eating disorders through the movement towards the conformity of her own conservative and patriarchal definition of what a woman should look like. The process of therapy is reminiscent of the British television program "What Not to Wear" which in the same way the hostess humiliates women so that they will conform to middle class stereotypical female images (McRobbie, 2004).

Rabin situates her own patriarchal views on gender within a construct that sees the individual patient as 'cognitively distorted'. This situates the 'disorder' within the psyche of the individual patient and describes her as deeply flawed (Moulding, 2003). Furthermore, Rabin (2003) ignores the role of discourse in constructing both her own and her patient's assumptions about gendered bodies. The feminist psychotherapist Hutchinson (1994) in a discussion of feminist approaches to difficulties with body image points out that "everything about our socialization as females in a patriarchal culture leads us to value our selves in terms of our bodies – as objects of love, as child bearers, as nurturers, and as ornaments for men" (p.153). Hutchinson (1994) further points out that the "obsessive and destructive relationship that most women have with their bodies is an internalization of society's relationship to women's bodies is an internalization of society's relationship to women's bodies – simultaneously one of contempt and worship" (p.154). Rabin (2003) and Hutchinson (1994) are in agreement that girls with anorexia have difficulties with body-image. However, Rabin (2003) situated within her unquestioned acceptance of patriarchal values desires to push these girls to the acceptance of normative, stereotypical perceptions of gendered female bodies;

whereas Hutchinson (1994) working within a feminist perspective aims to help "to return to my clients and readers the birthright to feel at home in the bodies they have – even if those bodies fail to conform to external or internalized standards of appearance" (p.153). While Rabin (2003) aims for conformity to patriarchal gender values; Hutchinson (1994) aims for the deconstruction of abstracted ideals of gender and their replacement with acceptance of one's physicality beyond standardized norms. From a critical perspective, the comparison of Rabin (2003) and Hutchinson (1994) reveals the role of theoretical orientation and gender positions on the understanding of anorexia nervosa. Rabin (2003) is trapped in her own acceptance of patriarchal gender roles which directly informs her understanding of both anorexia and its treatment. Ultimately, Rabin's theory and treatment of anorexia nervosa promotes normative positions of femininity and female image that support the hegemony of a patriarchal society.

Figure 7.8 A Picture Addressed in Rabin's (2003) Analysis of Anorexic Art

7.4.10 Dafna Rehavia-Hanauer (2003, 2006)

Rehavia-Hanauer a senior art therapist from Israel presents her theory of anorexia nervosa within two separate journal publications. In the first publication (Rehavia-Hanauer, 2003), published in English she sets out the major aspects of her theory of anorexia nervosa. In the second publication (Rehavia-Hanauer, 2006), published in Hebrew, she widens her theory through the application of existential philosophy and the presentation of extensive pictorial evidence. Rehavia-Hanauer's (2003, 2006) theory of anorexia nervosa results from a close analysis of the art therapy session summaries of 10 anorectic patients hospitalized in an Israeli medical centre. The session summaries included detailed information concerning the process of art therapy treatment and illustrations of the art products produced during treatment. The 10 patients ranged in age from 15 to 17.5 and were hospitalized for an average period of 5.9 months. A cyclical grounded theory approach was used in the analysis of these session summaries and art works. As stated by Rehavia-Hanauer (2003) this analysis revealed that "my patients were trapped in a pattern of conflicting themes" (p.137). Rehavia-Hanauer (2003) sees the concept of conflict as central to her definition of anorexia nervosa and

references Stern's (1991) psychoanalytical definition of anorexia nervosa. Stern (1991) states that "They [*anorectic patients*] are frozen developmentally, caught between opposing motivational currents" and goes on to blame the "mother-child dyad" for creating a "missing developmental experience" that is at the core of the eating disorder. Rehavia-Hanauer (2003) claims that the use of the concept of conflict is a "methodological decision", but has tied this concept to the psychoanalytic literature.

In her later article, Rehavia-Hanauer (2006) frames these conflicts within the context of the existential positions of Sartre (1982), Frankel (1970) and Laing (1977). The underpinning philosophical position presented by Rehavia-Hanauer (2006) constructs the individual as being faced with choices within a social context. As with other existential descriptions the individual is constructed as free within their world and as the centre of the decision making process. One aspect of being free is the option of facing the emptiness and nothingness of life in which the individual makes their own decisions. From an existential perspective this nothingness is important in that it allows the individual to construct her life and make her own meaning (Frankel, 1970). In her presentation Rehavia-Hanauer (2006) sees the girls who suffer from anorexia as situated between their desire to autonomously make decisions about their life and the presence within their social context of gender and social requirements. It is this overriding conflict between personal decision making and social developmental requirements that is translated into the more basic set of conflicts that are outlined in both of these articles. Rehavia-Hanauer (2006) specifies that these girls are in a state of fear and anxiety from both the nothingness of life and the social requirements that demand that they conform. The outcome is a state of panic that translates into a need to overcome this state of fear. The behaviours of anorexia nervosa thus become mechanisms for handling and controlling the fear and anxiety of both the nothingness and social demands.

The main result of both studies was the definition of six conflicts that were found to be present within the session summaries of the art therapy treatment of the ten adolescent girls diagnosed as having anorexia. The six conflicts are: 1) Verbal and/or emotional-behavioural resistance to art therapy and attraction to artistic materials and the creative art process; 2) Intensive creation of an artistic object and the desire to destroy it; 3) The desire and need to be looked after and held and the verbal inability to directly express this desire and need; 4) The need to be dependent and in a relationship with others and the desire to be autonomous; 5) The physical development of female sexuality and identity and the rejection of these physical developments and identity; 6) The need for complete control and the feeling of lack of control. The analysis of each of the conflicts presented by Rehavia-Hanauer (2003,

2006) consists of a description of the art process and products and the definition of specific behavioural and verbal indicators characteristic of the specific conflict.

At the end of her article Rehavia-Hanauer (2003) relates the emergent conflicts found within her analysis to the theoretical descriptions of anorexia found within prior psychological, psychiatric and art therapy literature. Specifically three different theoretical positions that propose "major explanations of anorexia nervosa" (Rehavia-Hanauer, 2003, p.147) were found to be significant as theoretical explanations of the presence of these conflicts within the patients. As stated by Rehavia-Hanauer (2003) the three theories are "Bruch's (1970, 1973, 1979, and 1985) explanation of anorexia nervosa in relation to powerlessness and control, Freudian explanations of anorexia nervosa as rejection of female sexuality and the object relation theory of anorexia nervosa in relation to the processes of separation-individuation" (p.147). The first two conflicts result from the context of the art therapy treatment. The first conflict is connected to Freudian theories of resistance as a defence mechanism. The second conflict is connected to Schaverien's (1994a; 1994b) theory of art therapy as a process of "scapegoat transference." The third conflict is connected to object relation theories and Luzatto's (1994) description of the double trap. Conflict four is connected to issues of separation-individuation within the family structure (Bruch, 1962, 1973; Minuchin, Rosman & Baker, 1978). Conflict five is connected to Freudian theories of anorexia as the rejection of female sexuality. Conflict six is connected to Bruch's (1973) theory concerning the need for control and feelings of powerlessness.

Rehavia-Hanauer (2003) describes anorexia nervosa as a "complex illness in which there is an interaction among opposing desires and forces on different intra- and interpersonal levels" (p.147) and proposes that the six conflicts that she defined through an analysis of the art therapy session summaries "describe the disorder" (p.148). In her final comments Rehavia-Hanauer (2003) states that these "conflicts embody a wide range of theoretical orientations and suggest that the description of anorexia nervosa needs a wide based eclectic approach" (p.148). In the later article Rehavia-Hanauer (2006) sees the girls with anorexia as "victims of their conflicts" that are experienced as "unsolvable" (p.16). As explained by Rehavia-Hanauer (2006) the presence of these conflicts cause high degrees of anxiety that strengthen the girls fear of the world and ultimately lead to the existential question of "to be or not to be" (p.17). They are afraid of the both the presence of nothingness and the social, developmental requirements of the world they live in. The solution posed by these girls is anorexia nervosa with the final determination of not being.

Rehavia-Hanauer's description of anorexia nervosa covers a range of psychological theories as well as proposing a philosophical interpretation as seen in the later paper. She presented an eclectic approach that indeed addresses a range of options but the options presented have at least one shared underpinning assumption. There is an existential assumption of the individual as the nexus of personal choice and the distancing and obscuration of social discursive constructs. As argued by Gimlin (1994) the use of psychoanalytical theory ultimately defines the individual patient as 'deviant' and 'personally flawed' as a result of her inability to handle crises of childhood and adolescence. Malson (1998) further points out that "patriarchal discourses present our often distressing experiences around eating and body weight as a problem of *individual pathology* rather than as a consequence of social oppression" (p.153). As seen in the previous analyses of both Crowl (1980) and Luzatto (1994) the disorder of anorexia nervosa is predominantly situated in the individual and the individual is described as deeply problematic. In the case of Rehavia-Hanauer's (2003, 2006) description of anorexia nervosa, the main characteristic of the flawed anorexic individual is the presence of a series of internal conflicts. While there is some recognition that these conflicts result from an interaction with physical sexual developments and social requirements, the emphasis is still on the presence of an internal conflictual situation in the patient with anorexia.

From the feminist perspective of considering the feelings and experiences that are expressed by the girls who suffer from anorexia, it is important to note that a key feature of the description of anorexia nervosa that arises from Rehavia-Hanauer's (2003, 2006) work is the presence of anger and resistance in these girls. As stated by Rehavia-Hanauer (2003, 2006) these girls resist their physical sexual development and the associated social pressures placed upon them as a result of this development. As noticed by Rehavia-Hanauer (2003, 2006) the artist who suffers from anorexia also exhibits a desire to destroy her own art work and self starvation can be seen as a form of aggression. Within the art work presented in the 2006 paper there is a collection of images of aggression (relating to self, the female, body image). In one picture a thin woman's body is depicted falling backwards onto a pointed sword that is in the middle of her back. In another picture a woman's face has an arrow embedded in her forehead and her face is a broken contour (see Figure 7.9). In yet another picture a sexually contoured female body appears with a blindfold and hands and body connected to black ropes. Within this collection of pictures, in addition to the presence of images of aggression, female gender roles are addressed. In one picture of a statue made by a patient with anorexia a pregnant female body is depicted without hands, legs or facial

features. The statue is reminiscent of a fertility goddess and seems to limit female existence to the role of having children. In the picture of the blindfolded, tied female sexual body drawn in bright red and situated in the centre of the page is suggestive of the positioning of the figure as a sexual object (see Figure 7.9). In another piece the more mundane everyday role of women is addressed in which a male and female figure are found standing facing one another. They seem to be adolescent and they are wearing underwear or swim suits that cover their sexual areas. Within Rehavia-Hanauer (2003) the artist with anorexia who created this piece is quoted as describing the two figures as Adam and Eve (see Figure 7.9). She described the male figure as dirty and in a dialogue she created between the two figures she specifies the following complaints about the male figure "I have been waiting for hours" and "I did the shopping and you didn't come" (p.145). There is attraction between the male and female figures (with the man holding the apple) but at the same time expressed disappointment. In conjunction with the role assigned to women, the visual representation of the women's bodies conforms to these assigned roles.

There is a relationship between the images of aggression, women's roles and body image. Images of male aggression are accompanied by the presentation of helpless woman's bodies. On a basic level, the presence of aggression in these images suggests that these girls are afraid of hostility, sexual harassment, rape and other forms of physical assault. There is recognition within these images of the ways women are seen and the gender roles that have been assigned to them. The images, quotes and descriptions provided within Rehavia-Hanauer's (2003, 2006) work suggests that there is multidirectional anger in these girls' experience. Although not explicated within her reported analyses, from a feminist perspective this anger can be interpreted as directed at the gender roles and forms of female physicality that society demands from them and at the same time directed against themselves for not being able (or willing) to fulfil these roles and physical forms appropriately. They object and resist female gender roles and body images at the same time as feeling the need to conform to them. Once again as seen in previous analyses of art therapist understandings of anorexia nervosa, the role of gender and its connections to the discursive situation of the girl who suffers from anorexia is not foregrounded.

The decision to organize the description of the art therapy process and art works of these patients into six dichotomous conflicts is a decision that directs a very specific way of understanding anorexia nervosa. The construct of the conflict creates a choice between two dichotomous positions with positive and negative values assigned to each of the positions. The positive values that are presented consist of attraction to the creative process, intensive

creation of artistic objects, acceptance of caring and holding, movement towards autonomy, acceptance of sexual development and roles, and an enhanced sense of control. The 'conflict' is basically the presence of the negative side of resistance to the positive value. Based on this description the core therapeutic understanding is that treatment involves solving the conflict through the girls' acceptance of the positive value through the removal of the girls' resistance. This usage of conflict pathologizes the girls' resistance to social norms and directs them to accept the positive socially defined values and also exposes the therapist's core beliefs.

There is a deeper issue in relation to the way conflicts are used in this set of studies. It is worth noting that the specific set of positive values come from the researcher's acceptance without critical reflection of a series of discursive descriptions of 'normal' behaviour that come from both societal discourses as well as disciplinary psychological positions. In this formulation therapy is a movement towards conformity and acceptance of normative gender roles and positions ultimately supporting the hegemony of a patriarchal society. As argued by Hare-Mustin (1987) if "we assume that one way is right, the other is wrong, we are led to what is called fallacy of opposites" (p.261). Using a sociological perspective Turner (1984) argues that patriarchal society translates the control (or lack of control) as expressed in woman's bodies into moral positions. From this perspective, female obesity is a sign of loose morality. The outcome of this position is that male society, expressed in the discourse of medical rationality is directed at controlling women's bodies. Using Foucault's concept of panoptic disciplinary power, Bell (2006) notes that the medical protocols of hospitalized, girls who suffer from anorexia describe a therapeutic process that employs "various tools of surveillance and routinization as a means to 'cure' the anorexic patient" (p.282). For Bell (2006) the medical institution's treatment of anorexic girls is built on the principles of the "idealized prison in which the jailer is neither seen nor heard but in which the prisoner is always observed and hence brought under control" (p.282).
Against this patriarchal discursive backdrop, the concept of conflicts is doubly troubling; it both situates the anorexia within the individual patient thus avoiding a discussion of societal and discursive positioning and directs a therapeutic process which involves enforcing conformity to patriarchal values. It is worth noting that as analyzed by Gimlin (1994) ultimately the social value that these girls are supposed to conform to is a "cultural model of femininity that is unattainable" (p.107) and as such treatment based on the movement towards conformity will not resolve the problems these girls experience. As seen in previous applications of psychological theory to evidence from the art therapy process, the experiences

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and feelings of these girls within the wider discursive social context is obscured through this usage of conflicts.

Figure 7.9 Pictures Addressed in Rehavia-Hanauer's (2006) Analysis of Art

7.4.11 Lisa D. Hinz (2006)

Lisa Hinz is a clinical psychologist and registered art therapist working in the American context. Hinz presents her understanding of anorexia nervosa in a 2006 book dedicated to this topic. She starts her explanation of anorexia nervosa by positing a series of positive traits that characterize persons with eating disorders. According to Hinz (2006) the "positive traits" of "caring, sensitivity, and intelligence" can "often serve as the genesis" of an eating disorder (p.24). Her explanation of this position is that children of this type within "abusive" or "dysfunctional" families "try to fulfil inappropriate parental needs and expectations" (p.23). She goes on to explain that these children's "own needs go unmet and they adapt to this deprivation by meeting needs with food" (Hinz, 2006, p.25). Specifically in relation to anorexia nervosa, Hinz (2006) claims that the patient with anorexia "turns psychic pain" into a "physical phenomenon" and that these "concrete physical symptoms say what cannot be spoken in words" (p.25). These concrete symptoms change the home relationship in that "parents no longer make inappropriate requests of her" (Hinz, 2006, p.25). Hinz (2006) summarizes her treatment of eating disordered patients by stating that these patients "were particularly sensitive to interpersonal dynamics and care intensely about family members. Deep sensitivity and caring caused them to take on emotional burdens – usually without being asked – that eventually proved harmful to their physical and emotional health" (p.26). The inappropriateness of these children's situation and the difficulties they face make them feel "overwhelmed", a sense of "shame and self-doubt" and to judge themselves "harshly for perceived failures" (Hinz, 2006, p.26). These children "do not display their own anger, fear, or shame at the inequities of the circumstances" (Hinz, 2006, p.26).

The relationship to food of these patients is explained by Hinz (2006) as a "way to control their emotions and as a way to nurture themselves emotionally" (p.26). Food fulfils the role of distracting "thoughts from failure", "soothe feelings" and "fill spiritual voids" (p.26). As explained by Hinz (2006) for anorexics "food restriction" is used to "reduce

awareness of their feelings and needs" (p.27). Ultimately the rituals and practices around food fill these patients with a "sense of shame that overshadows positive traits" (p.26). Treatment against this backdrop consists of reconnecting these patients with their positive qualities by addressing the "target areas for healing: problem solving, reclaiming emotions, body image, self-acceptance, and spirituality" (Hinz, 2006, p.27).

Hinz's (2006) theory has three aspects: positive qualities assigned to the patient with anorexia; the role of a dysfunctional or abusive family; and the relationship to food. In relation to the patient, Hinz (2006) avoids the trap of characterizing these girls as deeply personally flawed. Rather she takes the same external behavioural and perceptual manifestations of anorexia that others have noted and defined them as positive traits. However, it should be noted that these positive qualities are still situated in the individual psyche of the patient with very little consideration of the broader discursive contextualization of gendered identity. In relation to the role of the family Hinz specifies that her aim is not the assignment of blame either on the patient or her family. As stated by Hinz (2006) blaming "parents or other persons for the part they played in the development of an eating disorder is not productive" (p.28). She sees the eating disorder as a "type of adaptation the sufferer made to a difficult situation" (Hinz, 2006, p.28). While Hinz specifically distances herself from the position of blaming families, her theory which situates the 'genesis' of anorexia within abusive and dysfunctional families does have an accusatory aspect to it, even if she as a clinician does not wish to express this within the therapeutic relationship.. In relation to the role of food, Hinz's (2006) without specifically referencing object relations theory still constructs her understanding of the role of food on this conceptual basis. For patients' who suffers from anorexia, food is constructed by Hinz (2006) as a replacement for the early functions of her mother as nurturing and soothing. The restriction of food thus becomes a rejection of the mother and a movement towards supposed autonomy. This use of object relations even without it being acknowledged or referenced brings with it accusatory claims concerning close caregivers and family. Hinz (2006) tries hard in her written statements to counter these accusatory frameworks but they still exist within her core understanding of the phenomenon of anorexia.

This situation of the presence of accusatory concepts which are explicitly avoided by the therapist-researcher reflects a far deeper cultural understanding and response to issues of diversity. As with the concept of political correctness (prevalent in public discourse in the US since the mid 1990's), rather than contending with racism, the onus is placed on addressing the superficial characteristics of racism in everyday public speech. While this sanitizing of

presented, public speech may be necessary to counter the propagation of further discriminatory thought, the mere removal of offensive language does not change underlying power relations found in social structures and represented in private speech and thought. Political correctness is not usually a critical act of analysis, awareness raising and social change; it is usually a public relations act which covers and hides existing inequalities. In fact as argued by Lazar (2005) it is more difficult to conduct feminist analyses in the 21st century as a result of the ways in which gender discrimination has been hidden. Hinz's (2006) commentary on being non-judgmental towards, girls, mothers and families is welcome within the framework of previous positions within art therapy that have directly blamed women for anorexia nervosa; but her underlying positions still hold accusatory assumptions and avoids the social contextualization of anorexia nervosa by focusing on families and individual patients

A different aspect of this same process of decontextualization is the emphasis on an instrumentalist approach to the treatment of anorexia nervosa. The majority of Hinz's (2006) book provides specific methods for working with eating disordered patients in relation to the target areas of problem solving, reclaiming emotions, body image, self acceptance and spirituality that she has identified as requiring 'healing'. This emphasis on methods of working with patients contextualizes the treatment of anorexia nervosa to the therapist and patient. Once again the social contextualization and broader discursive understanding of anorexia are distanced from the therapist and her understanding of the issues in anorexia nervosa. The underlying assumption is based on the idea that anorexia is situated in the individual girl and that by the application of a series of in-room activities that a resolution can be reached. The methods presented are very structured and detailed which aims to teach other therapists how to treat anorexia. But these methods do not require a deeper consideration of the discursive influences of anorexia nor to a deep contextualized understanding of where these methods come from. The actual proposed approach is reminiscent of Cognitive Behaviour Therapy that aims to overturn and replace negative thoughts through the imposition of other thoughts (considered to be more positive and objective). Consistently the first part of the methods presented consists raising negative aspects of the anorexic patients experience; the second part consists of changing the negative into a positive understanding which based on the therapist beliefs. There is no critical interaction with the sources of the presented negative understanding of the girls.

Hinz's (2006) final set of presented art therapy methods addresses the idea of healing anorexia nervosa by 'fostering a spiritual connection" (p.137). As stated by Hinz (2006) "No

amount of food consumed, food restriction, or food ritual will ever fill the hungry soul. Until patients establish a spiritual connection – whatever that means for them – they will feel a certain level of emptiness" (p.138). Her aim is to facilitate a spiritual connection that will allow these patients to have their "hearts, minds and souls filled" and "have a foundation for giving of themselves in relationships" and "comfortably fulfil their own needs and those of others" (Hinz, 2006, p.138). This call for creating a spiritual connection is infused with a Christian understanding and is not in any way critically appraised. There is no understanding that religion can construct and support gender inequality and that a belief in God can be a force for discrimination and not a force of emancipation. This focus of spirituality and the role of God in treating anorexia nervosa once again distances any discussion of the role of society in the discursive construction of anorexia nervosa. When God is invoked then the whole of the social realm is belittled and the role of society in constructing illness is ignored.

From a critical perspective, this combination of political correctness, an emphasis on detailed method description and presentation, the proposition that negative thoughts be replaced by positive ones and a discussion of spirituality leads to a situation in which anorexia nervosa is decontextualized from its social and discursive frameworks. Hinz's (2006) position on anorexia nervosa ignores social contextualization and situates anorexia nervosa in the frameworks of the individual and her family. The solution proposed involves transforming negative thoughts into positive ones and bringing her to acceptance of her position as defined by God through the application of a series of defined procedures. While the explanation and approach proposed by Hinz (2006) is different from pervious approaches, the underlying problems are similar. The girl and her family are still the focus of the theory, the social and discursive context is ignored and the position of women is still situated within patriarchal hierarchical frames of reference.

7.4.12 Donna J. Betts (2008)

Donna Betts is an art therapist working in the American context. In her chapter within a recent book on expressive therapy approaches to the treatment of eating disorders (Brooke, 2008), she outlines her own usage of art therapy within the framework of a specific treatment centre of which she is a member. This centre utilizes what is termed a Recovery Model of treatment and offers a partial hospitalization model in which eating disordered patients reside in apartments adjacent to the clinic. After partial hospitalization these patients continue treatment in their home setting. This context and concept of treatment influences Betts (2008) presentation of art therapy.

Betts (2008) usage of art therapy as presented in her article consists of both assessment and treatment. Specifically Betts directs her attention to the way in which art therapy can be used as a tool for the assessment of progression in relation to therapy. She outlines and presents pictorial evidence of two art therapy assessment techniques that she uses – Bridge Drawing and the Separation from the Eating Disorder technique. In both cases, these assessments are repeated throughout the partial hospitalization as a "tool in determining clients' weekly progress" (Betts, 2008, p.16). The concept is of movement towards health that needs to be measured so as to determine when partial hospitalization will end.

Underpinning the Separation from Eating Disorder technique is the idea of a split between what Betts terms as a "True Self" and the eating disorder. As stated by Betts (2008) the True Self "refers to attributes of an individual's identity that contribute to a sense of wholeness and well being" (p.15). The eating disorder is characterized as an "overpowering entity" and associated with what Claude-Pierre (1997) terms as the "Negative Mind". Referencing Bruch (1962) and Claude-Pierre (1997), Betts claims that "people with anorexia tend to feel split, as though they have two minds". For Betts working within this Recovery Model approach to eating disorders, treatment consists of separating the eating disorder from the patients 'True Self.' As stated by Betts (2008) "To achieve recovery, the eating disorder must be separated from the True Self" and the progression of treatment consists of helping the "client to defeat the eating disorder" (p.18).

Betts (2008) also specifies some additional characteristics of anorexia nervosa drawn mainly from the cognitive approaches to eating disorders. Patients are described as having "maladaptive belief systems about food" (p.15); a "disturbance of delusional proportions in the body image and body concept" (p.15); are unaware of their "inner psychological and physiological processes" (p.21); and have issues with "control and perfectionism" (p.15). The assumption is that movement "away' from the eating disorder will entail improvements in relation to eating disordered behaviours but that some cognitive disorders may not change at the same pace. As specified by Betts (2008) there are situations in which the "client feels that he or she has made some emotional progress (e.g., increased self-awareness, positive outlook), but body image is still a problem. This usually coincides with the client's improved ability to separate from his or her eating disorder" (p.17).

The Recovery Model and the specific setting that Betts (2008) describes are characteristic of American health care issues in which hospitalization is limited through concerns for financial responsibility and measurement of change is paramount. Hence her specification of assessment as a measure of progression. The Separation from the Eating

Disorder assessment technique, which she developed within the setting of her treatment program, consists of asking the patient to first name the eating disorder, then to create a picture of the named eating disorder and then to create a picture of the patients 'True Self'. After the creation of these pictures, images are cut out and the patient is asked to draw an 'environment' for these cut-out figures and patients can attach the figures in different locations. According to Betts (2008), "Once a week, clients use their Separation picture to gauge their progress, by moving the ED figure and the True Self pictures" (p.19). The picture is assumed to reflect the "client's current reality of having to share his or her life with the eating disorder with the ultimate goal of moving farther and farther away from the disorder until this shared environment becomes obsolete, and the true self reigns" (Betts, 2008, p.19).

Figure 7.10 is an example of the figures of Eating Disorder and True Self as produced by one specific patient. Betts (2008) presents the pictures as an example of the Separation from the Eating Disorder technique and does not enter into an analysis of the figures themselves, except to point out that Satan was a common representation of the eating disorder. What is interesting from a feminist perspective is the gendered nature of these two figures. The eating disorder in the form of Satan seems to be male, muscular and threatening. The True Self representation is an emaciated feminine figure with long hair, a long elegant dress and accessories such as a bracelet and pointed shoes. In Figure 7.10 and in the adjacent quote from the patient herself, the male female relationship of these figures becomes apparent. As stated by the patient and graphically represented in the picture itself, the dainty and feminine True Self is "in ED's lair, under his power/arm because I still feel stuck in his world" (p.19). In other words, the patient clearly states a power relationship with the male represented figure as controlling the female figure. The placement of the female figure over the male sexual organs has some sexual overtones; however these are not directly addressed by Betts. Betts (2008) does raise the issue of what she calls "sexual maturity" in relation to another art therapy method that she discusses. In her discussion of the Self as Seed method she states that "eating disorders are used to deny sexual maturity and to reject adulthood" and through Betts discussion of a specific patient's treatment it is clear that progression involves "increased confidence to face the inevitability of becoming a woman" (p.21).

Betts (2008) definition of anorexia nervosa and her approach to treatment situate the phenomenon of self starvation within the patient. The concept of an internal split consisting of a True Self is drawn from Winnicott's work within object relation theory and places blame on the mother for the construction of a false self in the developing child. However, direct blame against the mother is not expressed within Betts (2008) description. Her approach is

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somewhat decontextualized avoiding any historical assignment of blame and rather choosing to focus on the internal faults of the patient herself. As with Hinz (2006), Betts adheres to the external manifestations of political correctness in relation to mother blaming but does not address the underlying accusatory frameworks that still exist within her theory. As opposed to Hinz (2006), Betts (2008) devalues the patient directly. In particular the girl who suffers from anorexia seems to suffer from a series of cognitive misperceptions concerning food, body weight, body shape and her self. The possibility of being threatened by a patriarchal world is not presented as part of the discussion and there is no consideration of the situation of women as a contributing factor to the development of anorexia. In particular the idea that these so called cognitive misperceptions could be internalized external representations situated in a prevalent patriarchal discourse is not addressed. As with the case with Rabin (2003) treatment seems to consist of movement towards acceptance of predefined female roles within the world. The distancing of the eating disorder as an entity and the acceptance of new behaviours as the central aspect of therapy seems to suggest a movement towards conformist female roles as the guidelines for improvement.

Figure 7.10 Pictures Addressed in Bett's (2008) Analysis of Art

7.4.13 Claire Edwards (2008)

Claire Edwards, a publishing art therapist in the Australian context, outlines her understanding of anorexia nervosa in a recent book on expressive therapy approaches to the treatment of eating disorders (Brooke, 2008). At the beginning of her chapter, Edwards (2008) states that the purpose of her chapter is to incorporate a "feminist analysis of eating issues into art therapy" and that this approach "may be beneficial to female clients who are struggling with eating issues" (p.29). At the end of her chapter, Edwards (2008) states that her purpose is "to describe a range of strategies which were used in developing a feminist approach to art therapy" (p.49). Edwards (2008) situates her discussion of feminism and eating disorders by arguing that art therapists may be "particularly conscious of the impact of visual imagery on vulnerable young women" and that there needs to be a consideration of "the cultural influences, such as magazine images, which put a premium on slimness" which may influence young women's "psychological development" (p.30). Edwards (2008)

summarizes her feminist approach to the art therapy treatment of women with eating issues as including "a socio-cultural perspective; an analysis of visual images in art and popular culture; a supportive, collaborative approach; active participation of clients; the importance of role modelling; and the therapist's awareness of their own body image issues" (p.36). Edward (2008) distinguishes art therapy from traditional, psychoanalytical, biomedical and behavioural approaches to treatment. These treatment methods can be perceived as "persecutory, abusive, invasive and judgmental"; in contrast, art therapy can be perceived as "empathic, empowering and fundamentally benign" (Edwards, 2008, p.32). Accordingly art therapy offers the option of "working in a more empowering and sensitive way with female clients" (Edwards, 2008, p.32).

Edwards (2008) situates anorexia nervosa within a broad spectrum of women's difficulties with eating issues and body image issues. This approach sees eating disorders and body image issues as "pervasive" and existing within a climate of "conflicting and unpalatable messages" directed at the identity of women (Edwards, 2008, p.29). Anorexia nervosa, like bulimia, is at the clinical end of this spectrum of responses to the cultural context. Edwards does not offer a developed explanation of anorexia nervosa. Her tendency in this article is to discuss what she calls "eating issues" a term which covers mild to clinical problems with eating as well as the practices of overeating and restrictive-eating. Edwards does briefly discuss the role of the family and the mother in contributing to the development of eating issues. Specifically she states that the mother identifies with the daughter's eating issues and that both share a "negative body image" (p.43).

This broad approach to the definition of eating disorders is reflected in the case study she presents. The data for the case study comes from a small group of two female participants which was constituted by a social worker and herself. As stated by Edwards (2008) "the theme of the group was not specifically related to eating issues" but these were raised within the discussions. Edwards (2008) states that eating issues were understood, by her, as "an underlying dynamic" (p.43). The case she presents is of an overweight patient who was during her teens defined as anorexic. The data collected consisted of asking the patient what was the "most significant event" in the week's sessions and what was the "most significant image" (Edwards, 2008, p.40). In relation to a collage made by this patient, Edwards (2008) characterizes this painting as expressing "the contrasting themes of powerful and powerless" (p.42) which she later sees as a dualism of male and female. Edwards (2008) quotes the following statement made by the patient in relation to the collage: "I could really think about the things that made me feel powerless" (p.43). Edwards does not report how this statement

or collage were addressed. In particular, it is not clear how the connections between eating disorders, powerlessness and gendered identity were handled (if at all). This is characteristic of the other descriptions that Edwards (2008) provides. In relation to another task in which the patient was asked to draw a "self portrait as an animal in a safe and unsafe place" (p.44), the patient drew a picture of the donkey Eeyore which she described as "sad, lonely and fat" (p.45). It seems that her directive tasks raise the sense of female stereotypes and social identities and associated feelings; but it is unclear what exactly the therapist does with this information. Unless handled carefully and redirected, the raising of consciousness in this way can reinforce the same stereotypes and paradoxically lead to an enhanced sense of powerlessness. In the case presented by Edwards (2008), the report does not specify what actually happened in relation to this image and the art therapy process. But it is notable that it was reported that the patient following these two sessions stated that "she wanted to take a 'heap of medication' with the goal of ending up in hospital" (Edwards, 2008, p.45), perhaps noting her increased sense of powerlessness.

Edwards (2008) approach to feminist art therapy with eating disorders as exemplified in the writing of this chapter consists mainly of prescriptively specifying the strategies that need to be used by the art therapist. Edwards approach to feminist art therapy focuses on the tasks, activities and strategies that she assumes need to be followed. It is an approach that is characterized by instrumentalism more than a developed and presented philosophical position. As quoted by Edwards (2008), Joyce (1997) has stated that feminist art therapy is a "philosophical approach" and not a "prescription of techniques" (p.30). But this is not advice that Edwards (2008) follows. The problem with situating feminist art therapy in instrumentalist terms of activities, tasks and strategies is that the meaning of all action is ultimately contextualized and as such the specification of action without social and philosophical contextualization can lead to very different outcomes than those assumed.

In the case of Edwards (2008) her willingness to enter into the usage of CBT (cognitive behaviour therapy), with its associated locus of control in the therapist and unbalanced power relations with the patient is problematic. While claiming the desire to empower patients through feminist therapy, she advocates the integration of CBT which is based on the subservience of the patient. Edwards (2008) presents CBT and art therapy as "complementary approaches" with art therapy helping CBT to "overcome some of the disadvantages of a purely CBT approach " by "allowing the emotional expression derived from art therapy to balance out the more cognitive bias of CBT" (p.39). CBT is presented as an "intellectualization" of the disorder and art therapy, in this presentation, is given the role

of emotional facilitator. Edwards creates a dichotomy which directly parallels the stereotypes of male and female roles (Hare-Mustin, 1987). CBT is also based on a dichotomous concept in which there are negative and positive thoughts that are assumed to influence a patient's self esteem. The negative thoughts are those that the patient has; the positive thought are those that are 'facilitated' by the CBT coach-therapist. Therapy in the CBT framework consists of transforming and overturning the patient's negative thoughts. However, these thoughts are never tied to any historical or discursive context. CBT avoids addressing gendered relationships that underlie the structure of society and in fact enacts a male gendered relationship to these girls which reinforces their core sense of powerlessness. The CBT argument is that by making these girls think in accordance with CBT methods they achieve greater sense of self worth. But the actual method reenacts the wider power relationship in which these girls are required to be subservient and accept the authority of others and as such seems a questionable method for treating anorexia nervosa. Even CBT researchers have pointed out that there is little evidence that CBT is an effective treatment of anorexia nervosa (Woolrich, Cooper & Turner, 2006). In Edwards (2008) presentation, art therapy is being used as a compliant (rather than complementary) method that allows CBT to enact its own gendered power relationship in relation to the patient. Edwards (2008) integration of methods is easy when an instrumentalist approach is taken; but is highly problematic when philosophical orientations are included. It is possible that Edwards works in an institution which forces her to subordinate art therapy to the frameworks of CBT (which says something about the hierarchical position of art therapy). Edwards (2008) does present an introduction to feminist art therapy with eating disorders and a list of issues that need to be addressed. However she does not seem to really incorporate the core philosophical understandings of what a feminist approach consists of and this directly influences how she describes and treats anorexia nervosa.

7.5 Summary of Critical Perspectives

In the previous sections, a critical review of the historical description of anorexia nervosa by individual researchers within the art therapy literature was presented. The next chapter will utilize this data and present a broad discursive description of art therapy and the way in which the concept of anorexia nervosa has been constructed in this discipline. But before we turn to this analysis, in this last section I would like to present a summary of the critical perspectives I have taken in relation to the art therapy literature dealing with anorexia nervosa. My aim is to explore how specific discursive positions taken within the art therapy literature produce meanings that construct anorexia nervosa and women in particular ways.

This overview is an attempt to raise consciousness within the field of art therapy and at the same time function as a precursor for the gendered, socio-cultural theory of self starving that appears in the postscript to this dissertation.

In analysing and critiquing the art therapists who have proposed empirical and theoretical understandings of anorexia nervosa, one characteristic is very apparent. All the art therapists in this corpus draw on psychological theory in developing their positions. The type of psychological theory used is different for the various practitioners and moves from psychodynamic and psychoanalytical approaches to cognitive behaviour therapy. But all of the art therapists presented here draw on some psychological theory in discussing anorexia nervosa. Accordingly, one critique that runs through my analysis of this literature is the consideration of the ramifications of this borrowing of psychological theory. This is based on the Foucauldian understanding of the archive and how discourses function and interrelate.

As an initial question we could ask what this borrowing of psychological theory says about the position of art therapy in relation to other clinical disciplines and it is clear that art therapy has a subordinated role. But more importantly for this specific section, my critique of the usage of psychological theory relates to its uncritical borrowing more than the borrowing itself. There is a naïve assumption about psychological theory that runs through the art therapy literature on anorexia nervosa. The theory is assumed to be neutral and descriptive. This assumption ignores the feminist critiques of the misogynist and accusatory nature of these theories. As argued by feminist researchers (see for example Chesler, 1972; Hare-Mustin, 1987; Maracek & Hare-Mustin, 1991) psychological theory in all its forms is susceptible to misogynist gendered assumptions. When psychological theory is borrowed and used in a naïve fashion, the gendered assumptions and accusatory narratives present within the core theory are replicated in the art therapy literature.

Several positions on anorexia nervosa drawn from the psychological literature were directly criticised in my analysis and need to be mentioned here. I have criticized assumptions about what Hare-Mustin (1987) has called "noxious" mothering for their blind construction of accusatory causal narratives situating the development of anorexia nervosa within early mothering. My critique is that these narratives are clearly misogynist, completely ignore even mentioning (let alone accusing) the other parent the father and avoid the social and cultural context of early development. Rather these positions put a singular focus on one parent the mother and blame her for all that is wrong. Another but related critique relates to the role of family in developing anorexia nervosa. Once again, these family orientated positions blame mothers but ignore the role of families in transmitting socio-cultural values.

A different by similarly problematic naïve assumption that runs through the majority of the art therapist literature (with the exception of perhaps Maclagan, 1998) is the psychiatric assumption that mental phenomena are situated in the individual. As argued convincingly by Hogan (2001) mental illness can be seen as respondent to social context and not as resultant from the flawed nature of the individual. The patient with anorexia nervosa is consistently presented as a deeply flawed individual suffering from a range of negative personality traits (manipulative, trapped, borderline personality…etc) and as being cognitively impaired (body image distortion, misconceptions about food…etc). As with other aspects of the borrowing of psychological theory, this assumption about the individual reduces the number of variables that are considered in relation to the development of self starvation among women. The socio-cultural context is completely ignored. Furthermore, the positions taken in relation to these women are reminiscent of positions taken towards women in the 19th century and seem to reconstruct older stereotypical positions about the inherent flaws of women. The naïve usage of psychological theory brings with it the historical positions found within this discourse and in many cases as analysed here misogynist and accusatory positions towards women.

This avoidance of the role of gender and understanding the ways in which women are situated and constructed within discourse is a central critique that runs through all of my analyses of individual art therapist positions on anorexia nervosa. When Luzzatto (1994) describes the girls in her study as feeling persecuted or Fleming (1989) presents a picture of female body being touched and they both assume that these are purely internal feelings situated in the individual resulting from problems in early mothering, I have criticised them for not addressing the far more obvious explanation that this is a gender based fear of a world in which being a woman is threatening. A theme running through the art works presented in this analysis is that of fear of harm and humiliation. There would seem to be good evidence to conclude that the girls presented within this literature are deeply concerned with their safety and that this is related to the development of becoming and being a woman in the world. In other words, gender positioning within these girls experience and socio-cultural discursive positioning needs to be analysed and not assumed to be an imaginary construct of the individual patient and a result of early mothering.

A different issue related to the lack of a critical understanding of gender that appears in several of the art therapists is the propagation of patriarchal discourse that defines specific and normative roles for women. For some art therapists, such as Rabin (2003) acceptance of this normative role is what treatment aims for. There is no consideration of the different ways

in which gender can be constructed and the negative positioning that may be inherent in the acceptance of normative gendered positioning. Once again this is a naïve and uncritical understanding of the way women are positioned in society and assumes that patriarchal positions are an unquestionable (and even desirable) biological reality.

In the next chapter a broad historical description of the construction of anorexia nervosa in the art therapy literature will be presented. But what the current summary of my critiques of the existing art therapy literature does is explicate some of the issues that have formed the existing literature and points at which different directions could have been taken. In particular, this summary has highlighted the ways in which misogynist and accusatory positions concerning women have entered into this literature through the naïve borrowing of psychological theory and the ways in which gender and the discursive, socio-cultural context has been avoided as part of the explanation. In my last chapter, the postscript to this dissertation, I will propose a gendered, socio-cultural theory of self starving women as a way of addressing this need within the art therapy literature. My criticism that appears in the current chapter points to the direction that needs to be taken in developing a new theory of self starving women.

Chapter Eight

The Disciplinary Construction of Anorexia Nervosa in Art Therapy

8.1 Introduction

The aim of this chapter is to present the first analysis of the disciplinary discourse of art therapy and the ways in which anorexia nervosa and women are constructed in this discourse. Malson's (1998) work has provided a detailed poststructuralist analysis of the development of the concept of anorexia nervosa within the psychological and psychiatric literature but ignored the field of art therapy. Accordingly, this chapter which builds upon the individual reviews and analyses presented in Chapter Seven aims to construct an understanding of disciplinary discourse in the field of art therapy and the ways in which this discourse constructed the concept of anorexia nervosa. As with previous genealogies the understanding of both disciplinary discourse and the construction of a concept such as anorexia nervosa has a historical aspect to it. As such this chapter provides a historical overview of the field of art therapy and the development of the concept of anorexia.

8.2 A Brief History of Approaches to Art Therapy

The position of the picture or art work within the field of art therapy is a defining issue of the discipline of art therapy (Schaverien, 1992). As with other disciplines, art therapy is a name that captures a range of positions and approaches and is not a unified concept (Hogan, 2001, 1997). However, all art therapy approaches assume that art can "respond to human suffering" (Levine, 1999, p. 11) and that art and art work has healing potential (Hogan, 2001). The role of the art work, the relationship among the artist, art therapist and art work and the process of producing an art work are central to the understanding of the discipline of art therapy. In order to explore different options for positioning art within art therapy and to develop an understanding of disciplinary discourse, in this section I will provide a brief overview of approaches to art therapy utilized in the 20th and 21st centuries. As seen in Hogan's (2001) history of art therapy in Britain, the early beginnings of art therapy can be found in 18th and 19th centuries. Hogan (2001) in her analysis specifies three basic types of art therapy in the 20th century: analytic art therapy, art psychotherapy and art therapy. *Analytic art therapy* is defined as an approach that draws on analytical psychology and "emphasizes the *transference* relationship between client and therapist, which is given central place in the interpretation of the therapeutic encounter" (Hogan, 2001, p. 21). As argued by Schaverien (1992) in a book aimed at developing analytic art psychotherapy, this approach draws upon Jungian psychology and attempts to fully explicate the role of art work as "an object of transference" (p.7). *Art psychotherapy* has deep roots within the field of art

therapy and can be traced back to the beginnings of the field in the writings and practices of the Freudian art therapist Margaret Naumburg. As stated by Naumburg (1950/1973) art psychotherapy is "dynamically orientated art therapy" which corresponds to the Freudian psychoanalytic practices and positions the art work as embodying unconscious material. Schaverien (1992) in her critique of art psychotherapy points out that within this approach the picture may "be reduced to a mode of description of a state or an illustration of the transference" (p.7). This is a critique that is further developed by Hogan (2001) in her description of art psychotherapy as an approach that emphasizes "the importance of verbal analysis of the art work of their patients" which in extreme cases "may result in the art work becoming a mere adjunct to verbal psychotherapy" (Hogan, 2001, p. 21). *Art therapy* finds its source within the education art therapy work of Edith Kramer. For Kramer (2000) "art as therapy" emphasized the sublimative aspects of art production and as such art work can be a form of healing. Hogan (2001) in her analysis states that this approach "may not feel that a verbal analysis is necessary and may lay greater emphasis on the actual production of art work" (Hogan, 2001, p. 21). These three approaches to art therapy position the art work in different ways. Broadly, in analytical art therapy, therapy is situated in the art work itself through processes of transference; in art psychotherapy, the art work is seen as representing and embodying psychic states but the therapeutic process is enacted through verbal psychotherapy and; and in art therapy, the process of producing the art work is the healing process.

The well known American art therapist Judith Rubin (1987) in one of the first edited books designed to provide an overview of approaches to art therapy, divides art therapy into three broad types of approach which she terms *psychodynamic*, *humanistic* and *behavioural/cognitive/ developmental* approaches to art therapy. Under *psychodynamic* approaches Rubin combines Freudian and Jungian approaches and covers all three of Hogan's (2001) categories of analytic art therapy, art psychotherapy and art therapy. Under the heading *humanistic* approaches Rubin presents work from a range of theoretical perspectives including phenomenology, gestalt and the creative work of Alfred Adler. The connection between these approaches and the reason perhaps that they are organised together is what Rubin (1987) terms as " the optimistic view of human nature and of the human condition, seeing people in a process of growth and development, with the potential to take responsibility for their fate" (p. 135). As described by Rubin (1987) these approaches still draw upon psychological theories however they place the patient-artist as the centre of focus and emphasize the whole patient and their experiences in therapy. Finally, under the heading

of *behavioural/cognitive/developmental* approaches Rubin (1987) presents types of art therapy that share "an emphasis on learning and sometimes manipulate the therapeutic situation to facilitate the patient's acquisition of a new skill or behaviour" (p. 209). The approaches presented under this heading draw upon the cognitive psychological work of researchers such as Piaget (1954) and Bruner (1966) as well as more behavioural work such as that of Skinner (1953).

The approaches and types of art therapy discussed so far draw largely upon the history of psychology and are situated within that disciplinary context from the 1940s till the 1990s. As explicated in the brief historical analysis above the differences in approach resides in the different schools of psychological thought that they rest on. However, since the 1990s additional types of art therapy have been proposed. Of particular interest to this dissertation is the development of feminist art therapy (Hogan, 1997). Hogan's (1997) approach to the artist and the art work goes beyond the traditional assumption of mental disorders as situated in an isolated (albeit historical) psyche and moves towards a much deeper social and cultural contextualization of mental anguish. As stated by Hogan (1997) in her introduction "an individual's sense of sorrow, loss, anger, marginalization and oppression, or her embodied experiences of disability, impairment, abuse, pain or illness are not simply personal. These feelings, emotions and experiences arise from and are interpreted through that individual's place in culture and the social world" (p. 8).

In other words, within a feminist art therapy approach the patient is fully contextualized within her social and cultural world and is influenced and changed by the prevalent discourses of that environment. Art therapy within this context involves an interaction with the prevalent discursive positions that direct and form the personal response of the patient that has led to the occurrence and presence of symptoms and mental states that brought the patient to therapy. Feminist art therapy as the name implies is deeply interested in the position of women and the interaction of gender with the discourse of mental illness. But on a broader level, feminist art therapy involves a form of socio-cultural analysis and critical interaction leading to enhanced understanding of social contextualization and personal empowerment of the patient in the face of social and cultural discursive marginalization and oppression that is embedded in the patient and art work. As such, within feminist art therapy and other socio-cultural approaches the art work is seen as an expression of socio-cultural and discursive contextualization. The art work and the understanding of the art work by the patient and therapist is the outcome of a range of discursive positions. The analysis of these discourses and the interaction around the formative aspects of socio-cultural discourse is, in

itself, a therapeutic process designed to provide understanding, a range of options and ways of being, a different way of seeing oneself, emotional expression and release, and personal empowerment.

An additional direction of art therapy that developed in the 1990s is cognitive-behavioural, art therapy. Cognitive-behavioural art therapy as the name suggests finds its impetus from the emphasis placed by psychiatry on cognitive-behavioural psychology. As stated by Rozum and Malchiodi (2003), cognitive-behavioural therapy is a "highly intellectual method, dealing with logic and cognition and questions and answers" that conceptualizes therapy as a process through which patients cognitively interact with their thought processes. Patients are taught to "track, verbalize and record negative thoughts in writing" (Rozum and Malchiodi, 2003). Art work is positioned in a particular way within this approach. As stated by Rozum and Malchiodi (2003) the:

> "client will be making concrete representations or images of negative schema, anxiety-producing cognitions, and negative self-talk. These images can be powerful representations of the workings of the mind and interior life of the person" (p. 74).

This way of conceptualizing the art work sees it as a tool that can be used to elicit explicit understandings of self. The art work is seen as an illustration of the patient's conscious mind and understanding. The emphasis is on cognitive understanding and therapy involves directing the patient to understand themselves and their interactions in new ways. As stated by Rozum and Malchiodi (2003) the aim of this therapy is to "help clients reduce or eliminate negative cognitions and self-talk" (p. 80). In this sense, the art work becomes a source of information that the art therapist verbally addresses. An important aspect of the cognitive-behaviour therapy is the aim for consistent tracking of progress using a range of evaluative tools. The positioning of the art work as an illustrative tool reflecting conscious understandings also positions the art work as a method of evaluation which can be used to track patient progress. The production of an art work is thus instrumental and allows the cognitive-behaviour, art-therapist a way of evaluating whether there has been a change in the presence of positive and negative understandings of the self. Cognitive-behaviour art therapy in many ways has diametrically opposed assumptions to those of feminist art therapy as it situates mental disorder clearly in the patient and assumes large degrees of inherent self agency. Furthermore, from a client-therapist perspective it involves a power relationship in which power resides with the therapist who directs how the patient needs to think. It is

interesting to note that both of these approaches developed within the same time period the end of the 1990's and into the 21st century.

An additional development of the end of the 20th century and into the 21st century is the presence of spiritual art therapy. Two books at the beginning of the 21st century have offered theoretical explanations that present a provisional grounding for this type of art therapy. Ellen Horovitz (2002) in a description of her own journey to and usage of spiritual art therapy grounded in a Judeo-Christian context states that this form of treatment offers "an avenue for treating the whole person – mind, body and soul" (p. 7). She further states that spirituality situated in a therapeutic context can offer "solace when in the house of God" (p. 6). This emphasis on addressing the whole person is also emphasized by Mimi Farrelly-Hansen (2001) in her edited volume of a collection of different approaches to spiritual art therapy that covers a wide range of religious orientations from both East and West. As stated by Farrelly-Hansen (2001) "art making is inherently spiritual" and "spirituality is an important ingredient in therapy in becoming more whole" (p. 17). Inherent in the all the approaches to spiritual art therapy found within Farrelly-Hansen's (2001) collection is the sense of both art and spirituality going beyond the boundaries of the "skin-clad ego" (p. 24). The relationship to the art work and the art creation process is "about entering into a relationship with what is" that facilitates

> "a heightened awareness of self and other, a reawakening of the senses and the body, a new ability to inhabit fully the present moment, a sense of awe at the mysterious way images which visit us speak of realities beyond our conscious understanding, a greater sense of acceptance of all aspects of ourselves and others, love, compassion and gratitude for some larger, deeper, ineffable presence to which we all (humans, animals and plants) belong" (p. 24).

The art making process and the art work is situated in particular ways through this application of theological understandings to art therapy. Specifically, as in many religious settings, art and art making is a form of conduit through which a sense of awe and presence beyond the self is facilitated. Art in this sense allows the patient to experience a sense of belonging to something bigger than her/himself. As argued by Horovitz (2002) this may be especially important when the patient feels utterly depressed and despondent and God becomes the "last stopping ground" (p. 7).

On a different level, a more socio-cultural understanding of the role of spiritual art therapy suggests that religion needs to be taken into account when dealing with patients from specific cultural groups. As argued by Campbell and Abra Gaga (1997) in a description of

mental health therapy within a black community, patients have "absorbed from an early age a wealth of ideas from Christianity" including "good and evil, punishment and redemption; being cursed and blessed" (p. 221). Thus, patients with a particular religious understanding may use this system of thought to understand their own situation in life and experiences in the world. This socio-cultural understanding of spiritual art therapy also raises one of the concerns in relation to this approach especially from a feminist perspective, as many religions place stratified and hierarchical distinctions on the way society is organized. These definitions which include the positioning of gender and explicit gender roles can be highly restrictive and difficult to overcome as they are sanctioned by a powerful authority.

The brief history of art history approaches presented here represents developments which occurred in two main settings the UK and the US. While there are many similarities and overlaps in the approaches and development of European and North American art therapy especially the focus on art as central to the therapeutic process and interaction with psychological theory, there are some differences that need to be explicated. The most influential difference relates to the way health care is set up in the US as opposed to the UK. In the US all health care is directed through private insurance companies; while in the UK there is a National Health Service. This difference has meant that in the US system treatment is a far more restricted and controlled resource than in the UK system. The ramifications of this are that private insurance companies require explicated diagnoses according to the DSM, short term treatments with clearly defined outcomes and measureable and documented development throughout treatment. This system prioritizes the medical model of psychiatry and has directly supported the rise of CBT approaches to therapy. This same approach also puts art therapy in a difficult situation in that requirements such as directly measureable outcomes are quite difficult to achieve.

As can be seen in this brief history of approaches in art therapy during the 20th and 21st centuries there are different ways of understanding art therapy. A core shared discursive position among all art therapists is that art is central to the therapeutic process. Differences among art therapist reside in the way art is understood. While psychological theories and in particular what Rubin (1987) termed psychodynamic approaches dominated art therapy up until the 1990s, more recent developments such as feminist art therapy and spiritual art therapy draw upon theories that go beyond psychology. One aspect that cuts across all these approaches is that art therapists tend to draw upon more powerful and accepted discourses to justify and ground their own approaches to art therapy. On a basic discursive level, art therapy seems to construct itself through an intertextual interaction with more widely

propagated theoretical positions from adjacent disciplines such as psychology or psychiatry. Art therapy seems to be very sensitive to changes in the social and disciplinary hierarchy of powerful discourse. For example changes in the preferred theory in the field of psychiatry and psychology are reflected in changes in the types of art therapy that are proposed. While psychodynamic theories were widely supported in the psychological and psychiatric literature, art therapy was more grounded in these theories; when psychodynamic approaches came under attack in the 1980s and a move towards cognitive-behavioural approaches became apparent in the medical literature these started to appear in art therapy as well. Thus two core aspect of the disciplinary discourse of art therapy can be defined on the basis of this historical review: 1) the acceptance of art as central to therapy; & 2) the need of art therapy to justify therapeutic practice by addressing theoretical explanations propagated within the more powerful discourses such as those of psychiatry and psychology.

8.3 An Analysis of the Discursive Positioning of Art Works

As seen in the previous section, disciplinary discourse in art therapy is formed by the interaction of two guidelines: the usage of theoretical explanation from adjacent therapeutic fields and the central understanding that art is therapeutic. As such, a central tenet of art therapy discourse is the development of ways of understanding and positioning patient art work in theoretical terms drawn from other fields. In order to further understand the nature of disciplinary discourse in art therapy, the relationship between these two discursive guidelines needs to be explicated. In this section, I will present a new analysis of the way the art work is positioned and conceptualized within art therapy. This analysis results from a close reading of the art therapy literature dealing with anorexia nervosa presented in the last chapter and the historical review that appears above. The resultant analytical tool provides insight into disciplinary discourse and the way this discourse directs understanding and will be used in the next section to explore the historical development of the concept of anorexia nervosa within the art therapy materials described in Chapter Seven.

An analysis of the specific ways in which individual art therapists explored anorexia nervosa and the approaches within the field of art therapy, reveals that art works can be positioned in at least six basic ways: 1) as an *expression of subjective experience and understandings*; 2) as a vehicle for the *embodiment of feeling and unconscious material*; 3) as a *representation of internal psychodynamic states*; 4) as an *expression of social-cultural and discursive contextualization*; 5) as an *expression of a spiritual state and situation;* and 6) as an *instrumental tool of therapy and evaluation.* This classification system of ways of approaching art work within art therapy allows differences in the approaches to art therapy to

be explored and models of disciplinary functioning to be explicated. The six ways are significantly different in their underpinning conceptions of what the art work is. In the sub-sections that follow each of these positions is explained.

8.3.1 Art as an Expression of Subjective Experience and Understanding

As a very basic position the development of an art work by a patient in therapy can be understood as expressing personal, subjective and autobiographical experiences. The approach is phenomenological in that the art work is understood as an expression of experience as felt and understood by the artist and not in any way an objective description of some outside reality. The understanding that the art work can express subjective experience situates the art work as a form of subjective negotiated history in which the artist recreates their understanding of past and present, on-going experiences. The creation of the art work within the art therapy setting involves the reconstruction of the subjective experience and can be a source of understanding concerning the way the artist sees and understands their experiences. In many ways this first way of positioning the art work is the most direct as it approaches the art work, its portrayed images, its relations, and its verbal contextualization by the patient, as the artist's construction of their own experiences. It is an artistic negotiation of the artist's experiences and expresses the artist's immediate understanding in the setting that the art work is produced.

8.3.2 Art as an Embodiment of Feelings and Unconscious Material

The concept that the art work embodies feelings and unconscious material is based on a Freudian concept of the psyche that includes conscious and unconscious components of the self (Hogan, 2001; Schavarien, 1992). In this formulation the art work is an object that allows the movement of material from an unconscious to a conscious state similar to the Freudian position on dreams (Schaverien, 1994a). In this sense the art work can embody feelings and fantasies that are part of the artist's unconscious life but not necessarily consciously known to the artist. This role of the art work is conceptualized as allowing therapy to take place through the manipulation of the art work as a representation and embodiment of the internal unconscious world of the artist-patient. This position is closely related with Schaverien's (1992) extensive analysis of the psychoanalytical processes of transference and counter transference within the art therapy process. In this formulation the art work is seen as a transactional object that takes on unconscious content that once produced can be used to transform unconscious material to conscious understanding and that this constitutes the art therapy process.

8.3.3 Art as a Representation of Internal Psychodynamic States

The third way of positioning the art work is as a representation of internal psychodynamic states. This way of looking at the art work involves the application of psychological theory to the explanation of the components, relations and the artistic processes associated with the art work. This approach positions the art work as evidence that relates and exemplifies predefined theoretical constructs. Once the psychological theory has been defined in relation to the evidence in the art work (or processes of production) it is assumed that this is also evidence of the patient's internal state. Conceptually, the application of theory as an explanatory framework is a moment of intertextual and cross-disciplinary interaction in that the theories that are used to explain the art works are drawn from the field of psychology. The interpretive application of theory can be done in different ways. Schaverien (1992) objects to simplistic assumptions concerning any autonomous status of the art work in which specific objects depicted are assigned specific psychodynamic meanings. For example, the idea that art works can be 'read' through a fixed 'dictionary' of meanings which connect particular portrayed objects with specific psychodynamic meanings. For Schaverien (1992) and other art therapists, the art work should always be positioned in a triangular relationship with the artist-patient, the art work, and the art therapist. Picture meanings are dynamic and are interactive in relation to the artist-patient, art work and art therapist. Meanings (and thus the application of theory) results from a contextual consideration of what was depicted, what was done, what was said, and processes of transference and counter transference within the art therapy setting. It is important to note that this more complex formulation of the factors involved in the construction of meaning in relation to the art work still involves the application of predefined theoretical constructs. However, the range of evidence is much wider than a static consideration of the picture and a single predefined interpretation of the psychological meaning of an art object or process.

8.3.4 Art as an Expression of Social-Cultural and Discursive Contextualization

The fourth way of positioning the art work consists of addressing the art work as an entity that is contextualized within a specific social-cultural and discursive frame of reference. Positioning the art work in this way involves exploring the contextual references and relations to the wider social, cultural and discursive frameworks that have contributed to this specific representation. The art work (and by extension the patient-artist) are seen as constituted within a specific historical, discursive and social context and as such these frames of reference are reflected and represented within the art work itself (Hogan, 1997). The patient-artist may not be aware of the ways in which discourse has directed and constituted

their understandings and representations. As such this frame of reference may be hidden and considered a natural 'reality' by the artist-patient. By positioning the art work in this way, the art therapist enters into a much broader discussion with the social contextualization of the patient and the art work that can include explicit reference to the ways social definitions of gender power relations, social and economic status, race, ethnicity and sexuality and the way these impact patient identity and the definition of psychological illness. This way of positioning the art work moves beyond the assumptions of psychological approaches to therapy that situate patient difficulties in the patient or in early family relationships. This approach allows the therapist to discuss and explore the broad social-cultural discourse within which the patient, (her family) and art work are constituted. For example, Hogan's (1997) conceptualization of feminist art therapy positions the visual image as part of a social discourse that individuals reference in their construction of self and their position in the world. Art therapy in this framework involves interacting with this broader image and verbal based social discourse and its influence on the individual.

8.3.5 Art as an Expression of a Spiritual State and Situation

The fifth way of positioning the art work consists of seeing the art work as an expression of a spiritual state and situation. This approach is similar to the way psychodynamic theory positions the art work in that the art work is seen as a representation of internal state that is defined according to a theoretical (theological and pseudo-religious) position. As with psychodynamic theories, this approach positions the art work as evidence that relates and exemplifies predefined theoretical constructs. The discussion of the spiritual state of the artist-patient is extrapolated from the aspects of the art work and a theological explanation is applied to explain the internal, spiritual state of the patient. However, it should be noted that psychological theories tend to be far more detailed and mechanistic in their explanations of psychological disorders than theological theories. As utilized within the art therapy context, theology does not have the same degree of detailed explanation and classification as psychological theory. However, this does not mean that it has less explanatory strength for specific patients. If both patient and therapist work with the same theological understandings, the reference to a transcendent being that requires of believers specific codes of behaviour is a very powerful discursive influence. As with psychological theory, one of the issues with application of theological positions to the understanding of patient art work is that they may come with very conservative and discriminatory concepts of gender roles. In relation to gender and body, theological positions drawn from the Judeo-Christian heritage there is a tendency towards dualistic concepts such as spirit/body;

male/female; good/evil...etc (Maclagan, 1998). This Judeo-Christian dualism positions women in a secondary and subordinate role. An interpretive male gaze when backed by an ultimate authority is a powerful directive force that is difficult to counter.

8.3.6 Art as an Instrumental Tool of Therapy and Evaluation

The sixth way of positioning an art work consists of using art as an instrumental tool of therapy and evaluation. The emphasis is on the conscious mind of the patient and the way in which art can provide evidence of current thinking and understanding. This approach situates the art work within the context of a progression (or regression) within a specific therapy program such as those defined in cognitive-behavioural therapy. The art work as evidence of current thinking of the patient can be used for evaluation as well as a site for discussion of required changes in thinking that is part of the cognitive-behavioural training. In this sense the art work is instrumental in that it serves a purpose as evidence for assessing the state of the patient (Rabin, 2003). The art work is defined along structured, procedural lines and in terms of specific outcomes that are pre-determined (in the sense that the interpretation is limited to the predetermined lines of therapeutic progression). The social-cultural and discursive frame of reference in not addressed in any way and the art work is consider to be self explanatory within the context of a specific therapeutic progression.

8.4 The Discursive, Historical Construction of Anorexia Nervosa in Art Therapy

In this section, we will return to the issue of how anorexia nervosa is constructed within the disciplinary discourse of art therapy. Specifically this section reconsiders and summarizes the art therapy literature analysed in Chapter Seven by applying the tool described in the previous section which outlines ways in which art work is positioned. A consideration of the specific categories of art work positioning is a way of defining the discursive guidelines used to construct anorexia nervosa in the field of art therapy. A close consideration of the categories of art work positioning used by specific art therapist researchers in their definition of anorexia nervosa across a historical span of development, allows the specification of a historical model of the disciplinary, discursive guidelines within which the definitions of anorexia nervosa were constituted. Table 8.1 summarizes the categories of art work positioning used by specific art therapists arranged in chronological order.

An analysis of Table 8.1 reveals several interesting aspects of the historical development of the disciplinary discursive guidelines used to define anorexia nervosa. First of all the most highly frequent ways of positioning the art work of women with anorexia nervosa consisted of seeing the art works as an expression of subjective experience (category

1) and as a vehicle for the embodiment of feelings and unconscious experience (category 2). The use of these categories appeared in 9 of the 13 art therapists whose work was reviewed. As a basic discursive position categories 1 and 2 explain art as therapy as a medium for expressing experience and embodying feelings. These two categories construct a basic argument for bringing art into the realm of therapy and as such they are shared by a range of art therapists in this sample.

Name Year	1 Subjective Experience	2 Feelings/ Unconscious Material	3 Psycho-dynamic States	4 Social-Cultural Context	5 Spiritual State	6 Instrumen-tal Tool
Crowl 1980	X	X	X			
Murphy 1984	X	X	X			
Fleming 1989	X	X	X			
Luzatto 1994	X	X	X			
Schaverien 1994	X	X	X			
Levens 1995	X	X	X			
Maclagan 1998				X	X	
Makin 2000	X	X				
Rabin 2003	X					X
Rehavia-Hanauer 2003/6	X	X	X			
Hinz 2006					X	X
Betts 2008						X
Edwards 2008		X		X		X
TOTAL	9	9	7	2	2	4

Table 8.1 Frequency and Chronological Development of Specific Art Therapists' Categories of Ways of Positioning Art Work in their Published Understandings of Anorexia Nervosa

The third most frequent category was the positioning of patient's art work as a representation of internal psychodynamic states (category 3). Category 3 was used by 7 of the 13 art therapist reviewed. Furthermore, this category always came in conjunction with categories 1 and 2 creating 7 art therapists who used all three categories. These results suggest a very specific way of addressing art work which considers the subjective and emotional content of art work and also offers the options of moving to symbolic interpretation of the art work through theory application. Accordingly, a second and connected finding is that the most prevalent combination of categories consisted of the presence of categories 1, 2 and 3. This suggests that the integration of psychodynamic understanding is the most frequent (although historically situated) model of art therapy in working with and defining anorexia nervosa.

A third finding is that there seems to be a clear historical development in the way art works are positioned by art therapists in their definition of anorexia nervosa. From 1980 till 1995, the first six art therapists reviewed used the same set of categories and same dynamic model that consists of positioning art works as expressions of subjective experience, a vehicle for the embodiment of feelings and unconscious material and as a representation of psychodynamic states. This same model was also used by Rehavia-Hanauer in 2003 and 2006. However, following Maclagan's (1998) paper we see a shift in the categories used. In particular from Rabin's 2003 paper and until Edwards (2008) we see the presence of category 6 which positions the art work as a tool for therapy and evaluation and a dropping of the category 3 (art as a representation of psychodynamic states). This is a finding which closely models the developments seen in Chapter Six concerning the psychiatric discourse with a movement away from psychodynamic explanations. However, whereas in the case of psychiatry this resulted from the application of Neo-Kraepelinian guidelines, in the case of art therapy this resulted from an alignment with psychiatric discourse.

An additional finding is that following 1998 Maclagan's paper a wider set of categories is used including the social-cultural and discursive positioning of art works (category 4) and the positioning of the art work as a representation of a spiritual state (category 5). Accordingly, from a historical perspective it seems in relation to this analysis that the field of art therapy was historically constituted within a model that focused almost exclusively on concepts of unconscious materials and psychodynamic theory application; but that this unitary model has been replaced by a series of new directions. In particular, this new direction consists of a greater emphasis on instrumentalist approaches to the positioning of the art work of women with anorexia and an avoidance of psychodynamic theories. There is also some evidence in two of the art therapists reviewed of a greater interest in social-cultural and discursive contextualization; as well as some evidence of an interest in spirituality. Importantly the discursive, disciplinary guidelines of art therapy seem to have evolved from a more entrenched and monolithic understanding of the importance of psychodynamic theory into a more diverse set of approaches that paradoxically both decontextualize anorexia nervosa (as in instrumentalist approaches) and contextualize anorexia nervosa (as in social-cultural approaches).

8.5 The Main Art Therapy Models used with Women who Suffer from Anorexia Nervosa

The analysis of different ways of positioning art within art therapy and the analysis of the historical development of ways of constructing anorexia nervosa seen in the literature

reviewed for this dissertation, describe the ways in which specific disciplinary discursive positions generate particular understandings. In order to understand this process, the current section outlines the models of art therapy functioning revealed through the analysis of discursive positioning of art found in the academic art therapy materials that research anorexia nervosa. The next section (8.6) then utilizes these models to directly show how anorexia nervosa and women have been constructed in this discourse.

The findings as seen in Table 8.1 suggest the presence of two main disciplinary models, both historically situated, that have been used to define the phenomenon of self starving women termed anorexia nervosa within the field of art therapy. The models can be termed – the *Psychodynamic Theory Application Model of Art Therapy* and the *Decontextualizing Instrumentalist Model of Art Therapy*. In addition, to these two models, the beginnings of two new directions seem to be emerging. These deal with both spiritual and social-cultural approaches. In the sections that follow each of these models and directions is defined in greater detail.

8.5.1 The Psychodynamic Theory Application Model of Art Therapy

Within the corpus of published materials in relation to anorexia nervosa analysed for the current research project (and presented above) a prevalent model of functioning did emerge. This model addresses the art therapists who constructed their understandings of anorexia nervosa by using the first three categories - 1) as an *expression of subjective experience and understandings*; 2) as a vehicle for the *embodiment of feelings and unconscious material*; 3) as a *representation of internal psychodynamic states*. The specific researchers who used these categories were Crowl (1980), Murphy (1984), Fleming (1989), Luzatto, 1994, Schaverien, 1994, Levens, 1995, and Rehavia-Hanauer (2003, 2006). Within the corpus of art therapy materials explored for this study, there was a preference for the first, second and third ways of positioning the art work. However, a close consideration of the actual working of these art therapy understandings of anorexia nervosa reveals that the disciplinary discourse of art therapy had a preference for the positioning of the art work as a vehicle for the embodiment of feelings and as a representation of internal psychodynamic states. An analysis of the way these categories were used revealed that the understanding of patient art work as evidence of internal psychodynamic states emerged as a discursive guideline of disciplinary practice within the field of art therapy until the mid 1990s.

The emphasis on the art work as a representation of internal psychodynamic states has serious ramifications on the way patients and psychological phenomenon are understood and explained. Specifically, a particular type of statement becomes highly valued. As seen in the

critical summaries presented in Chapter Seven, the overall tendency within this model of art therapy was to lessen the importance of expressed experience and feelings and heighten the importance of explaining the artist-patient in the terms of internal psychodynamic states. This preference in relation to how the art work is positioned brings with it a preference for statements that redefine the art work as an example of predefined theoretical psychological understandings. In other words, the disciplinary guideline of preference for statements that explore patient art as a representation of internal psychodynamic states directs a process in which expressed experiences and feelings are devalued, marginalized, avoided or even erased through the application of predefined theoretical understandings.

This preference for explaining the patient in terms of psychodynamic states was found to involve a characteristic way of constructing meaning. This way of generating an understanding of the art work of anorexic patients involved five stages: 1) The definition of a particular picture (or set of pictures) as characteristic of the body of work produced by girls with anorexia; 2) The provision of an artistic analysis of the objects depicted, the relations in the picture, the processes of production and statements made in relation to the pictures; 3) The abstraction and generalization of the aspects of the art work; 4) The specification of the abstracted and generalized aspects of the art work as representative of predefined psychological theories; 5) Positioning the patient in relation to the predefined psychological theory. These stages once applied moves the understanding of the art work away from the experience of the woman with anorexia nervosa and towards theoretical understanding. To a large extent the subjective experience expressed through the picture is erased and replaced with a predefined and abstracted theoretical position.

This process of devaluing, hiding and ultimately erasing the stated experience and feelings of the artist patient in relation to their art work through the application of a predefined psychological theory has very serious ramifications from a feminist perspective. As seen in the reviews of specific art therapist who utilize this model presented in Chapter Seven, the psychological theories are laden with misogynist assumptions concerning women.

The overall direction of all the art therapists who utilize this model is to explain the phenomena of self starvation by referencing early mothering and family experiences. From different psychological theoretical positions the mother is presented as a central causal factor for the onset of anorexia nervosa and accordingly, these theories either directly or implicitly blame mothers for the development of their daughter's disorder. The same psychological theories see the self starving girl as deeply flawed and in many cases extremely manipulative. The presence of a psychological theory functions as an overriding interpretation of expressed

experience and defines mothers and daughters (and by extension all women) in a very negative light. This model of interpretation tends to ignore the artist-patient's expressed understanding of her own experiences and favours instead distancing and obscuring this experience through the process of predefined theory application. This erasure, obscuration and distancing of experience is significant from a feminist perspective because what is hidden is the artist-patient's experience as a woman in the world and any options for seeing the social-cultural-discursive context within which self starvation is formulated. The girls expressed experience is replaced with specific gender roles found within the predefined theories that define women in negative terms.

8.5.2 The Decontextualizing Instrumentalist Model of Art Therapy

This model was found to be have evolved in the first decade of the 21st century from 2003 till 2008. The central aspect of this model is the emphasis on positioning the art work as a tool for therapy and evaluation. The art therapists who utilized this model were Rabin (2003), Hinz (2006), Betts (2008) and Edwards (2008). From a philosophical as well as an operational perspective, instrumentalist approaches situate the phenomenon of the self starving women in the patient herself. The instrumentalist approach works in the here and now of patient-therapist-art work interactions and distances any historical, social, cultural or discursive construction. Specifically, in this set of descriptions of anorexia nervosa, instrumentalist approaches were accompanied by the distancing of psychological theories.

A characteristic aspect of the positioning of art works as instrumental entities is the emphasis placed on both patient evaluation and prescription of art therapy methods. The overall approach places emphasis on the 'doing' of art therapy and on extrapolating assessment findings from specific art work cases. This approach situates the psychological disorder clearly within the individual patient. In the description of art work usage within the articles presented by these researchers, the art work was from evaluative procedures and was discussed in relation to patient recovery and development. A close consideration of patient development as expressed in the usage of the art works reveals an interesting intervention of predefined and unexamined gender understandings in the actual analysis and conclusions from the assessment. Since the art therapy assessments are not situated within a broader discursive frame of reference, the art therapist sees the results only in relation to the tool itself. But as in the case of Rabin (2003) or Betts (2008) more normative concepts of gender are present in the actual interpretation.

A different but equally significant aspect of the instrumentalist category as used here by these art therapists, is that instrumentalist statements and approaches are accompanied by

statements of political correctness designed to distance from the explicit discourse comments concerning the assignment of blame to mothers and families and the definition of the anorexic girl as flawed. This is once again an aspect of discourse that was observed in the development of psychiatric discourse in the 21st century as well. The emphasis is on the usage of correct methods (the instruments of art therapy treatment) and close evaluation of patient progress towards reintegration in society through the acceptance of her female identity and roles. But, as with Lazar's (2005) analysis of a variety of different contexts in the 21st century, the presence of politically correct language does not actually change underlying misogynist positions. Quite the opposite, what actually happens is that these types of position are just better hidden within the discourse itself. In particular, power relationships which existed in male dominated society are still enacted but without explicit commentary. As such within the current set of art therapists we find pressures to see treatment as a move to the acceptance of a predefined, socially approved female gender roles and the willingness to use Cognitive Behaviour Therapy with anorexic patients. In both cases, treatment in instrumental terms is not a neutral activity (as assumed by instrumentalist approaches) but rather an enactment of a power relationship in which the self starving women are forced to change the way they think and accept these proposed gender roles. The patients in this sort of interaction are supposed to be subservient to the role of the therapist. This is an enactment of classic female gender roles with women being seen as passive and needing explicit direction. The political correctness of this approach and its avoidance of exploring social discursive contextualization leave existing gender definitions in place by driving them underground in the discourse but still active in the actual interpretation and direction of therapy.

The instrumentalist positioning of patient art work was enacted within the art therapy articles reviewed as an extended presentation of 'how to do' and 'how to use' various techniques and assessment procedures within the treatment of anorexic patients. The emphasis was on the doing without any commentary concerning the context of usage. It is interesting to note that art therapy was situated by these art therapists in relation to other therapeutic approaches without consideration of the philosophical, epistemological conflicts which might exist between the usage of art therapy with other approaches. In particular, the openness of artistic interpretation was replaced with a more deterministic understanding of the findings in relation to desired therapeutic outcomes. The emphasis is on the patient. Her art work is seen as evidence of the state of the progress or regression of the patient within the course of treatment. Mothers and family contexts are not blamed explicitly or explored. The tendency seems to be to define these girls as cognitively distorted and assume that reversal of

this cognitive distortion in relation to their own physicality is the solution to anorexia. This limiting of anorexia to the girl and her perception of body and appearance also severely limits the ways in which self starvation by women is understood and presented. In particular, from a feminist perspective the instrumentalist approach with its desire to sanitize the discourse and treatment of these self starving girls avoids the deeper and still present issues of being a woman in the 21st century.

8.5.3 Emergent Directions for Art Therapy: Spiritual and Socio-Cultural Approaches

As seen in Table 8.1 from 1998 with Maclagan's paper a different and less homogenous set of categories of positioning art work were presented in the published materials of art therapists dealing with anorexia nervosa. From the perspective of this study, one important direction is the emergence of discussions of the social-cultural context of anorexia nervosa. Maclagan's (1998) paper is the most advanced position of this type with Maclagan situating the art work as a reflection of a much broader social-cultural problem promoted within the media and dealing with the contradictions of consumer society. This way of positioning the art work changes the focus and source of the phenomenon of self starving women from the individual and her family to the broader frame of social discourse. Edwards (2008) in a similar manner, points to the possible relationship between gender, media and anorexia nervosa. For both Maclagan (1998) and Edwards (2008) this entry into the social-cultural-discursive construction of self starving women is accompanied by the presence of other categories of positioning art works. Maclagan combines his social cultural analysis with spiritual concerns. The art work not only reflects a social-cultural problem but also a spiritual crisis. For Edwards (2008) a stated interest in socio-cultural contextualization is connected to the presentation of instrumentalist approaches. For Edwards (2008) the social-cultural is reformulated as a series of ways of doing art therapy with anorexic girls thus overturning the core understandings of social-cultural contextualization. However, the presence of statements that position the art work in relation to its socio-cultural context does offer a series of options for more in-depth and extensive feminist understandings of self starving women and is to be seen as a positive development from the perspective of this study.

A different development connected to Maclagan (1998) is the presence of the spiritual positioning of art works in the understanding and treatment of anorexia nervosa. This can be found in different ways in both Maclagan (1998) and Hinz (2006). This usage of spiritual positioning can be seen as problematic from a feminist perspective as it brings into play a range of gendered positions in relation to women and their role. These can be hidden in the

underpinning dichotomies used to define the cultural context (as in Maclagan) or more explicit in the actual definition of the women (as in the case of Hinz).

8.6 Anorexia Nervosa and the Construction of Women in the Discipline of Art Therapy

The aim of this section is to answer, in a manner that integrates the understandings of specific art therapists, the core content questions of how the phenomenon of self-starving women is explained in the disciplinary discourse of art therapy and how women are represented. In order to achieve these aims the models of art therapy defined above are used as a way of organizing the different discursive positions presented within the reviewed literature.

8.6.1 The Psychodynamic, Art Therapy Definition of Anorexia Nervosa and Women

Within the corpus of academic, art therapy materials analysed above that utilizes the psychodynamic model, the explanation of anorexia nervosa is situated in relation to established psychodynamic theories of anorexia nervosa. The prevalent direction of explanation was based on object relations and was dominated by discussions of early mothering. The commonest explanation of anorexia nervosa involved the ideas that negative early mothering experiences had created a situation in which the daughter (the patient with anorexia) felt persecuted (Luzzato, 1994a, 1994b); controlled (Crowl, 1980); rejected (Crowl, 1980); powerless (Crowl, 1980; Rehavia-Hanauer, 2003, 2006); conflicted (Crowl, 1980; Rehavia-Hanauer, 2003, 2006); has low-self esteem (Crowl, 1980, Rehavia-Hanauer 2003, 2006), a joke (Crowl, 1980), isolated (Murphy, 1984), facing hostility (Murphy, 1984) and resistant (Rehavia-Hanauer, 2003, 2006).

The patient with anorexia is described by these art therapists as mother's little daughter (Crowl, 1980), in desperate need to take control (Crowl, 1980; Rehavia-Hanauer, 2003, 2006; Schaverien, 1994a, 1994b), as feeling worthless and marginalized (Crowl, 1980), having an unconscious desire to stay a child (Murphy, 1984), incorrectly programmed (Murphy, 1984), manipulative (Murphy, 1984), vulnerable (Luzatto, 1994a, 1994b), persecuted (Luzatto, 1994a, 1994b), trapped (Luzatto, 1994a, 1994b; Rehavia-Hanauer, 2003, 2006), suffering from a borderline disturbance (Schaverien, 1994a, 1994b), terrified of fragmentation (Schaverien, 1994a, 1994b), and as trying desperately to avoid and reject the onset of female sexuality (Crowl, 1980; Levens, 1995; Murphy, 1984; Fleming, 1989, Schaverien, 1994a, 1994b, Rehavia-Hanauer, 2003, 2006). This list of traits associated with the anorexic girl is supported in the presented articles with comments concerning the deeply disturbed nature of the anorexic girl who has a range of psychological problems.

In these same psychodynamic explanations mothers were presented as controlling (Crowl, 1980), rejecting (Crowl, 1980), excessively anxious (Murphy, 1984; Schaverien, 1987, 1992, 1994a, 1994b), pushing food (Murphy, 1984), overly protective (Murphy, 1984), lacking empathy (Fleming, 1989), not providing a responsive early environment (Fleming, 1989), intrusive (Felming, 1989), identifying sexual areas as negative (Fleming, 1989), not providing protection (Luzatto, 1994a, 1994b), and as inhibiting separation and individuation (Levens, 1995). For these art therapists, the causes of anorexia nervosa are deeply situated within the failings of the mother in early childhood. As seen in the list of characteristics outlined above the mother is presented as deeply flawed as both a caregiver and as a person. The mother-faults are assumed to have created the forms of deficit that later manifest themselves as the symptoms of anorexia nervosa in later puberty. The explanations between these art therapists are different but they follow a common equation: problems in mothering in early childhood equal the onset of anorexia in later life. This equation reduces the active variables in the construction of anorexia to the mother and daughter and places blame on the mother while describing the daughter as deeply flawed. With this direction of explaining anorexia nervosa it is easy to see how negatively women are constructed within this discourse.

From the perspective of the categories of explanation proposed by Malson (1998), the psychodynamic model falls under the heading of psychodynamic disturbance and familial pathology. The explanations proposed within this model draw their explanatory power from the psychodynamic and family structure theories. What these art therapists have done is to show ways in which art process and products can be understood using these borrowed explanations. Thus the medium and specific visual representations are novel but the underlying explanations are situated within existing theoretical models.

8.6.2 Instrumentalist Approaches to the Definition of Anorexia Nervosa and Women

Instrumentalist approaches to the definition of anorexia nervosa are based on a different set of assumptions concerning the definition of anorexia nervosa. The predominant understanding of anorexia nervosa within this group describes anorexia nervosa as a cognitive dysfunction. This cognitive dysfunction can be a "disturbance of delusional proportions in the body image and concept" (Betts, 2008: Rabin, 2003), negative body image (Edwards, 2008), and misconceptions concerning food, body weight and shape (Betts, 2008). Within these understandings of anorexia nervosa the self starving girl is described as having issues with perfectionism and control (Betts, 2008), of feeling powerless (Edwards, 2008), as

unaware of internal psychological and physiological processes (Betts, 2008), and as having unmet needs (Hinz, 2006).

This approach is far less concerned with the causes of anorexia nervosa or the explicit construction of accusatory narratives. However, explanations are offered that present some sources for the development of anorexia; but they are less mechanistic and determinist than the psychodynamic theories. For Betts (2008) the eating disorder is seen as an "overpowering entity" that is part of a split mind that characterizes the anorexic girl. Rabin (2003) and Hinz (2006) have implicit accusatory explanations directed at the anorexic patient's family and their inappropriate requests or basic inadequacies. Rabin (2003) blames a permissive society and feminism for confusing gender roles and Edwards (2008) proposes that media images may have a role in the onset of anorexia.

Within the instrumental approach to the understanding of anorexia, women are defined through the presentation of the qualities of the anorexic girl. The anorexic girl is deeply flawed in relation to her cognitive understandings. Her perceptions are distorted and treatment is situated broadly within the reversal of these cognitive dysfunctions. As with the psychodynamic theories these girls are still defined as wishing to avoid acceptance of their gender roles with treatment directed at making them accept these defined roles. The decontextualized nature of this approach sees the problem as consisting of the patient's need to adjust themselves to a dominant discourse through the application of a series of procedures and tasks without analyzing that discourse .

From the perspective of Malson's (1998) categories, the instrumentalist model falls under the headings of cognitive dysfunction and body image distortion. In an even clearer manner than the psychodynamic model, the explanation of anorexia nervosa is drawn from an understanding of anorexia as a cognitive disorder. Art therapy in this framework becomes a means of eliciting information that can then be processed along cognitive behavioural lines.

8.6.3 Emergent Directions and the Definition of Anorexia Nervosa and Women

There are some different directions to the explanation of anorexia nervosa. For Maclagan (1998) anorexia is a reflection of cultural conflicts. In this explanation the social-cultural context is addressed and analysed for its impact on the development of anorexia nervosa. The specific content of Maclagan's theory involves an analysis of consumer society and its inherent contradictions. Edwards (2008) and Maclagan (1998) see a role for media images and messages in the development of anorexia nervosa. In addition both Maclagan (1998) and Hinz (2006) see a role for spirituality in defining anorexia nervosa. These approaches situate anorexia nervosa within a different context than the limiting frame of

mother-daughter (psychodynamic approaches) or patient cognition (instrumentalist approaches). The characteristics assigned to the anorexic girl in this context consist of desiring an impossible aesthetic perfection (Maclagan, 1998) and as such the anorexia is a response to an unachievable social message. The anorexic girl is a form of victim to the media messages of society. For Hinz (2006), the anorexic girl suffers from a spiritual void. However, within both the Maclagan (1998) and Hinz (2006) analyses there are still implicit negative constructions of women. Within Maclagan (1998) this relates to male/female; spirit/body dichotomies and in Hinz (2006) it relates to conservatively defined women's roles.

The emergent model consists of a collection of diverse directions. From the perspective of Malson's (1998) categories, only the socio-cultural studies can be seen as fitting under a heading in the original taxonomy. Malson (1998) did not have a category for spiritual understandings of anorexia and this was also not found in the published psychiatric literature. It is interesting that perhaps in the 21st century religion may also pose a powerful discourse that can be drawn upon in positioning art within therapy. The discursive principle of searching for a powerful adjacent explanatory frame to justify the art work as therapy is still present. The difference is the type of discourse that is addressed.

8.7 Understanding Disciplinary Discourse in Art Therapy

In this chapter, I have presented the first analysis of the disciplinary discourse of art therapy and the ways in which anorexia nervosa and women are constructed in this discourse. As a core principle of discourse, the field of art therapy was seen to be constantly working at justifying their a-priori belief in the value of art in therapy by utilizing a series of more powerful discourses from adjacent fields. Thus changes in the construction of anorexia nervosa from the psychodynamic model to the instrumentalist model really reflect changes within psychiatry and the importance that discipline placed upon cognitive behaviour models of therapy and the distancing and marginalization of psychodynamic approaches.

This subservience and self marginalization of the field of art therapy has deep historical roots. In considering Hogan's (2001) detailed analysis of the history of art therapy in Britain it is interesting to note the difficulties art therapists had in establishing themselves and their work as professional. Early moves towards the usage of art in therapy were constituted within and also explicitly drew on the discourses of psychology and psychiatry and later drew on the field of art (especially surrealism) to support their existence. There is a sense in which the art therapy process only becomes therapy once it is explained in the theoretical terms of more powerful and better established disciplines (in many cases

involving psychological discourse). Accordingly, many art therapists can be seen to self marginalize their own position and profession by situating their own form of therapy in the subordinate role of merely exemplifying borrowed discourses.

Within the disciplinary discourse of art therapy, anorexia nervosa was found to be explained in five of the categories proposed by Malson (1998): psychodynamic disturbance, familial pathology, cognitive dysfunction, body image distortion and socio-cultural context. These ways of explaining anorexia nervosa were seen to be in a process of historical change parallel to that of the field of psychiatry. Early explanations rested upon psychodynamic and familial explanations; later explanations were cognitive or socio-cultural. Within the field of art therapy spiritual explanations were also found as a way of theorizing anorexia nervosa that was beyond Malson's (1998) taxonomy or the field of psychiatry.

Chapter Nine

Summary, Argument, Findings and Ramifications

9.1 A Summary of the Main Argument

The argument put forward by this dissertation is that disciplinary discourse directs the construction of the concept of anorexia nervosa in particular ways that serve the purpose and understandings of each discipline. As such, this dissertation has explored the way anorexia nervosa and women have been constructed within the professional literature of art therapy and psychiatry. Importantly, this study offers the first poststructuralist genealogy of the construction of anorexia nervosa in the field of art therapy and the way disciplinary discourse works in that field.

As documented in this dissertation through the interaction with the field of art therapy, definitions and understandings promoted within psychiatry have a direct impact on understandings and clinical work in other adjacent fields. Art therapy was found to discursively construct itself in a self marginalizing way and to change and justify its therapeutic work in relation to discourses present within adjacent fields (with a particular sensitivity to changes in psychiatry and psychology). Accordingly, changes in the understanding of anorexia nervosa within the field of psychiatry were influential in changing understandings in art therapy.

One major outcome of this analysis of the disciplinary discursive construction of anorexia nervosa is an understanding of the direction of 21st century understandings of anorexia nervosa. In the psychiatric literature of the 21st century and particularly the proposed revisions of the influential DSM V there is a preference for biological and behavioural understandings of anorexia that neutralize gender and distance socio-cultural explanations. The gendered and socio-cultural understandings of anorexia nervosa are being actively distanced from the explanation of anorexia nervosa. This is highly problematic as there is quite obvious and empirically validated evidence positioning anorexia nervosa as a gendered, socio-cultural phenomenon predominantly afflicting adolescent women in Western and Westernized countries. The disciplinary discourse of psychiatry with its emphasis on the medicalization of anorexia nervosa and the requirement for explicit measureable diagnostic criteria has marginalized considerations of gender or socio-cultural context and preferred instead the promotion of biological and cognitive explanations. The field of psychiatry has chosen reliability of diagnosis (whether fictional or not) over the validity of its understanding of self-starving women.

One of the aims of this dissertation is to explicate the implications for the field of art therapy of this study and suggest ways in which art therapists who work with self starving women may modify their work. Accordingly, following a review of the main findings of this poststructuralist study of the construction of anorexia nervosa and women in the disciplines of art therapy and psychiatry, the chapter turns to the main ramifications of this study for art therapy – 1) addressing disciplinary discursive self marginalization; 2) integrating gendered, socio-cultural understandings into art therapy practice; and 3) the importance of developing gendered, socio-cultural (feminist) understandings of self-starving women.

9.2 A Summary of Findings

This dissertation consisted of three new studies of the construction of anorexia nervosa within disciplinary discourse (the corpus of research articles in psychiatry in 2009; an analysis of the DSM IV and proposed revisions to this document; and a comprehensive, analysis of the construction of anorexia in all the published research with the field of art therapy). This research extended what is currently known concerning the disciplinary discursive construction of the concept anorexia nervosa and women by exploring the field of art therapy for the first time and by extending existing poststructuralist studies of anorexia nervosa into the 21st century. In coming sections, I present a succinct summary of my findings. In relation to the final argument, the following issues will be addressed: the disciplinary discourse of art therapy; the disciplinary discourse of psychiatry; charting the interdisciplinary relationship between psychiatry and art therapy; the construction of anorexia nervosa; the construction of women in the art therapy literature on anorexia nervosa; the definition of anorexia nervosa in the 21st century; and the avoidance of gendered and critical socio-cultural understandings of anorexia nervosa

9.2.1 The Disciplinary Discourse of Art Therapy

The disciplinary discourse of art therapy was found to be constructed on two basic principles: the understanding that art is central to the therapy process and justification of art as therapy through the integration of explanatory discourses from adjacent fields such as psychology and psychiatry. Thus, disciplinary discourse in the field of art therapy consisted of positioning art work and the artistic process on an intertextual basis and within discourses from other disciplines. In the analysis of art therapist's ways of constructing anorexia nervosa the current study found six basic ways of positioning art (1) as an *expression of subjective experience and understandings*; 2) as a vehicle for the *embodiment of feeling and unconscious material*; 3) as a *representation of internal psychodynamic states*; 4) as an

expression of social-cultural and discursive contextualization; 5) as an *expression of a spiritual state and situation;* and 6) as an *instrumental tool of therapy and evaluation*).

Through the historical analysis of ways in which anorexia nervosa had been constructed, these six ways of positioning art were further found to form into 2 basic models of functioning: the psychodynamic model and the instrumentalist model. From a historical perspective the field of art therapy was found to be moving from a more monolithic understanding of art within psychodynamic terms to an understand that was based on cognitive approaches. In the 21st century, in addition to cognitive models there was also the development of spiritual approaches to art therapy and the beginnings of a consideration of socio-cultural context. Broadly, understanding disciplinary discourse in art therapy involves considering how art is positioned in relation to other discourses and how these generate particular ways of understanding art, therapy and the patient.

9.2.2 The Disciplinary Discourse of Psychiatry

Since the 1980's the field of psychiatry has been concerned with the problem of reliability in relation to psychiatric diagnosis and this presumed problem was used as a justification for the development of a range of discursive changes to the discipline of psychiatry. During the 1980's and in a successful effort to establish centrality for the field of psychiatry, disciplinary discourse and the diagnostic process was aligned with Neo-Kraepilinian concepts of medical psychiatry. This realignment was directly tied to the rewriting and reconceptualization of the Diagnostic and Statistical Manual of Mental Disorders. The DSM was designed as a way of controlling the diagnostic process and attaining greater reliability and agreement in the diagnostic process.

Psychiatric discourse as constructed within Neo-Kraepelinian guidelines placed an emphasis on diagnosis, biology, explicitness and measurability and situated mental illness within the individual patient. Understanding mental illness was based on the search for medical explanations and explicit evidence in the form of behaviour or verbal statements. This created a very particular orientation for the generation of new research and the establishment of what is acceptable knowledge within the field of psychiatry. As a discourse, this approach foregrounded research that looked at biology and explicit behaviour, backgrounded socio-cultural understandings and avoided issues of gender. This produced a very particular way of constructing anorexia nervosa that was not based on empirical evidence but rather this a'priori way of preferencing a particular type of statement.

The renewed emphasis on medical psychiatry created a discourse that was intolerant of any other ways of constructing knowledge and directed a process of purging earlier

psychodynamic understandings of mental illness. The liking for biological explanations situated in the individual patient and the requirement for explicit and measurable aspects of diagnosis and treatment created a preference for medical and cognitive approaches as reflected in continuing changes to the diagnosis of anorexia nervosa.

An adjacent movement within the disciplinary discourse of psychiatry was an avoidance of accusatory statements or the construction of historical blame. In a form of sensitivity to aspects of political correctness, psychiatric discourse has seen a continual movement since the 1980's away for explicitly accusing parents or patients for the development of mental illness. This aspect of psychiatric discourse can be seen as part of the move away from psychodynamic understandings and as an increased emphasis on dealing with current states of the patient rather than inferring historical conditions. For the definition of anorexia nervosa the outcome of these discursive forces is an emphasis on the explicit bodily, behavioural and verbal manifestations of anorexia nervosa and a clear preference for cognitive-behavioural methods of treatment without any gendered or socio-cultural contextualization.

9.2.3 Charting the Interdisciplinary Relationship between Psychiatry and Art Therapy

In Chapter Two, I analysed an article by Frisch, Franko & Herzog (2006) that critiqued the research on eating disorders in the field of art therapy for not utilizing what they termed as "empirically valid studies" (p. 132). At this point in this study, it should be clear that statements such as these come from a series of assumptions that construct psychiatry as a discipline and that these guidelines were designed so as to provide psychiatry with the preeminent position as the source of knowledge on mental disease. The reinvention of psychiatry through the revision of the *DSM III* based on Neo-Kraepelinian guidelines produced a discourse that negated and delegitimized research by other psychiatrists, psychologist and clinicians of various types. In this sense, Frisch, Franko & Herzog's (2006) critique of art therapy research was part of a much wider and deeper disciplinary discourse designed primarily to negate other ways of constructing knowledge and part of a continuing process of enforcing the importance of psychiatry.

But it should be noted that while disciplinary discourse in psychiatry is directly involved in the construction of power through the negation of other knowledges; the discourse of art therapy is constructed through the appropriation of explanatory discourses from other disciplines. Thus while psychiatric discourse is quick to marginalize others; art therapy discourse is quick to accept more powerful positions in justifying its own therapeutic practice. As such, the relationship between psychiatry and art therapy is of an unequal power

relationship in which changes within psychiatric understanding of mental illness are accepted on the basis of authority by researchers and clinicians in the field of art therapy. From the perspective of knowledge construction and the acceptance of particular statements as valuable within discourse, the relationship between psychiatry and art therapy is mono-directional with art therapy accepting statements from within psychiatry but without psychiatry accepting statements from art therapy.

9.2.4 The Construction of Anorexia Nervosa

A review of the studies conducted in this dissertation demonstrates that within the fields of art therapy and psychiatry anorexia nervosa has been constructed in different ways. This finding, while self-evident in many ways, is still significant and validates previous findings presented by Malson (1998). There is a clear historical development and disciplinary influence on the way anorexia nervosa is defined and both diachronic and synchronic analyses reveal differences in what is emphasized in the definition of anorexia nervosa. This dissertation reaffirms the presence of multiple definitions for anorexia nervosa situated within specific historical and disciplinary contexts. This finding exemplifies the constructed nature of the concept of anorexia nervosa.

Using the categories of explanation proposed by Malson (1998) the historical development of the concept of anorexia within the art therapy literature moved from psychodynamic disturbance and familial pathology as found within the early psychodynamic model of art therapy to the cognitive dysfunction and body image distortion categories in the instrumentalist model of art therapy. In addition, at the end of the 20th century and into the 21st century there was some exploration of socio-cultural context and spiritual explanations of anorexia nervosa.

Within the field of psychiatry, as seen in the 2009 study, all ten of Malson's (1998) categories of explanation were used. However, for the researchers most closely related with the revision of the DSM IV there was a clear preference for the medicalization of anorexia nervosa found in the increased usage of the category of anorexia nervosa as natural disease and genetic predisposition. Furthermore, there was an increase in the usage of the categories of cognitive dysfunction and body image distortion. The categories of psychodynamic disturbance and familial pathology are still present but should be seen as on the decline from their prominence earlier in the 20th century.

In the discussion of the existing DSM IV and its suggested revisions it was interesting to note the difference between the main diagnostic criteria that were proposed which focused on physical and behavioural criteria and marginalized the socio-cultural aspects of anorexia

nervosa. This process was seen to be accelerated in the suggestions for the revisions to the category of anorexia nervosa which directly involved the gender neutralization of anorexia nervosa and the focus explicit physical and behavioural measures.

9.2.5 The Construction of Women in the Art Therapy Literature on Anorexia Nervosa

The construction of women is tied to the way anorexia nervosa is defined in the art therapy literature. As seen in the discussion of the historical development of this term, the field of art therapy moved from a psychodynamic model to an instrumentalist model and emergent model of explaining anorexia nervosa. Within the psychodynamic model mothers of anorexic patients and the girls who suffer from anorexia are described in an explicitly negative and accusatory manner. Broadly, early failures in mothering were seen as the cause of anorexia. The girls with anorexia, as a result of their mother's actions, were presented as feeling persecuted, controlled, rejected, powerless, conflicted, as having low self-esteem, facing hostility and as resistant. Among the explicitly negative traits of these girls were found descriptions which show them to be manipulative, desperate to take control, incorrectly programmed, trying to avoid or reject sexuality and trapped. Girls with anorexia in the psychodynamic art therapy literature are presented as deeply disturbed. Mothers within the psychodynamic art therapy literature are presented as controlling, rejecting, excessively anxious, as pushing food, overly protective, lacking empathy, not responsive, intrusive, as identifying sexuality in negative terms and as inhibiting separation and individuation. The mothers of girls with anorexia nervosa are constructed within an explicitly accusatory narrative that sees them as the main cause of the phenomenon of self starvation. This narrative ignores any aspect of the socio-cultural contextualization of women and reinforces broader discursive positions of how women are constructed.

The instrumentalist model avoids the explicit construction of accusatory narratives concerning women but still sees anorexic girls as deeply flawed and irrational. Within this model girls with anorexia are described as having a cognitive disturbance in the way they perceive the proportions of their body, misconceptions concerning body, weight size and food. Furthermore these girls are described as perfectionists, as feeling powerless, as having unmet needs, and unaware of their own internal psychological states. Within this explanation the girl with anorexia is presented as cognitively flawed and perhaps resistant to the normative models of being a woman. Treatment involves moving towards acceptance of normative female roles through the overturning of irrational thoughts and cognitive misperceptions.

Within the emergent model there are both socio-cultural explanations of anorexia nervosa and spiritual ones. Within the socio-cultural explanations the girl with anorexia is presented as a victim of unachievable social messages that are part of consumer society. The role of the media in promoting these messages is emphasized. The spiritual explanations of anorexia nervosa explain the girl with anorexia as suffering from a spiritual void. Tied to the spiritual explanations is a conservative understanding of the role of women which tends towards dualistic gender explanations.

Overall the construction of women in the art therapy literature on anorexia nervosa moved from explicitly negative characterizations of women to more subtly hidden negative descriptions. In the psychodynamic model women are clearly presented as flawed and to blame. In the instrumentalist model explicit blame has been avoided but women are still seen as irrational and cognitively flawed. In the spiritual literature women are expected to follow some predefined and rather conservative gender role an aspect that is also present within the instrumentalist literature. Socio-cultural understandings do see these girls as victims and thus there is some movement towards a broader definition of women as socially contextualized.

9.2.6 The Definition of Anorexia Nervosa in the 21st Century

An important aspect of this study involves the consideration of the way anorexia nervosa is understood in the 21st century. The art therapy literature shows a move away from psychodynamic explanations and towards cognitive ones (although this is not monolithic and there is also the presence of spiritual and socio-cultural explanations as well). In psychiatry the proposed definition of anorexia nervosa in the revision to the DSM IV (see Walsh and Sysko, 2009) situates the disorder in the individual and describes patients who are restricting their food intake in order to reduce their weight, have cognitive distortions in their understanding of their own weight and body shape and an irrational fear of gaining weight. The objective measure of low weight which cannot be explained except on the basis of the patient's behaviour is seen as the clearest indicator of the phenomenon of anorexia nervosa. As described by Becker, Eddy and Perloe (2009) "both low weight and the cognitive frame that supports it are intrinsic to AN" (p. 615). In other words, in this discourse anorexia nervosa is an illness that is characterized by the way an individual behaves by restricting the amount of food that they eat as a result of cognitive distortion and irrational fears.

Walsh and Sysko (2009), the head of the team of psychiatrists involved in spearheading the definition of anorexia nervosa in the DSM V, propose a revised set of criteria for the diagnosis of anorexia nervosa to appear in the new version of the DSM. In this document the proposal for the revised definition of anorexia nervosa is interesting in that

throughout the word "individual" is used in conjunction with the foregrounding of behaviour and the avoidance of personal agency. For example consider the following passage:

> "nnn.11, Typical Anorexia Nervosa
>
> A. Severe restriction of food intake relative to caloric requirements leading to maintenance of body weight below a minimally normal weight for an individual taking into account age and height (e.g., 85% of that expected)
> B. Evidence of intense fear of gaining weight or becoming fat, even though underweight.
> C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape or weight on self-evaluation, or denial of the seriousness of current low body weight.
>
> Note: amenorrhea is not required" (Walsh and Sysko, 2009, p. 10).

This definition of anorexia nervosa actively distances the concept of gender and socio-cultural context from within its bounds. According to the syntax of this definition "severe restriction of food intake" just takes place and is without an agent at all. The act of food restriction is foregrounded and the outcome is found in the body weight of the "individual". There is no recognition that according to psychiatric statistical data, the body that is being discussed is predominantly that of a woman (11:1 ratio of women to men). The final note concerning amenorrhea further distances the idea that anorexia has anything to do with a particular gender.

In the next two core criteria emotional and cognitive dysfunction are once again without an agent. There is some disembodied fear of weight gain or becoming fat and a series of cognitive dysfunctions. The source of these fears and cognitive disturbance is not mentioned or dealt with in any way. While no explicit causal explanation is presented, the reductive nature of the three core criteria for anorexia nervosa suggests a relationship. Basically, fear of gaining weight or becoming fat and/or have a disturbance in body weight or shape are the causes of restricted body weight. Thus, this definition achieves three aims: 1) it distances the concept of gender from the definition of anorexia nervosa; 2) it avoids any socio-cultural or psychological context for the appearance of anorexia nervosa; 3) it proposes a form of causal model (by association) that links self starvation to emotional fear of gaining weight and a series of cognitive dysfunctions.

As pointed out by Lazar (2005) power structures are maintained basically by hiding the presence of that power structure. In other words the naturalization of a power structure hides its discriminatory aspects. Specifically in the 21st century Lazar (2005) warns against

the neo-liberal discourse of post-feminism that sees equality among genders to have been achieved and thus promotes the concept of the individual. Gender according to this discourse is not important as we have moved beyond the stage at which gender was discriminatory. The definition of anorexia nervosa presented above falls into this category. The emphasis is clearly on neutralizing gender and avoiding socio-cultural contextualization.

The role of gender in this definition becomes much clearer when the outcomes of this way of defining anorexia nervosa are considered. So how will anorexia nervosa be treated upon the basis of this definition? If anorexia nervosa is constructed as behaviour directed by an irrational fear and a cognitive dysfunction, then these are the causes that need to be addressed in therapy. From the perspective of psychiatry (and picked up by art therapy) Cognitive Behaviour Therapy is promoted as the appropriate method for dealing with anorexia nervosa. Cognitive Behaviour Therapy shares with the Walsh and Sysko (2009) definition, several characteristics: it focuses directly on cognition, sees the individual as being able to change and adapt to its surroundings, and assesses explicit behaviour and language. As discussed by Kantrowitz and Ballou (1992) in an early feminist critique of Cognitive Behaviour Therapy (CBT), CBT overlooks the environmental context and creates a situation in which the women patient is informed how she should think and adapt herself. Furthermore, the lack of discussion of context leads to a situation in which the dominant societal discourse is considered to be the definition of normative and normal. Thus gender biases directly enter into the supposed value neutral discourse of therapy. Specifically, Kantrowitz and Ballou (1992) see CBT as based on a "restricted European-American androcentric view of human nature" (p. 84). In other words, acceptance of definitions of gender promoted and propagated within societal discourse suddenly became the aim of the therapy. As pointed out by Lazar (2005) while the language of current definitions of anorexia nervosa may have hidden gendered aspects of the phenomenon, the phenomenon is still gendered and the treatment of anorexia directed by gendered assumptions is all the more dangerous as they are hidden within the discourse of dysfunctional thinking. As seen in the analysis of the work of Betts (2008), Edwards (2008) and Rabin (2003), gender enters into the unchallenged definition of normative female behaviour and functions as a central part of the process of therapy.

9.2.7 The Avoidance of Gendered and Critical Socio-Cultural Understandings of Anorexia Nervosa

In the current version of the DSM IV and in the articles that discuss problems in the DSM and call for revision, there is ample evidence of the socio-cultural and gendered nature of anorexia nervosa. The most apparent workings of discourse in psychiatry is actually in the

way this evidence has been marginalized and placed as augmenting text rather than directly as part of definition and diagnosis of anorexia nervosa. The socio-cultural and gendered aspects of anorexia nervosa do not fit nicely with the discursive preference for positioning anorexia nervosa as a medical disorder situated in the individual and defining explicit measurable criteria for diagnosis.

At this point in the dissertation it is worth summarizing the evidence from within the psychiatric literature and even within the current version of the DSM IV that deals with the socio-cultural and gendered aspects of anorexia nervosa. First and most clearly the data on the frequency of anorexia nervosa among men and women clearly points to a gendered phenomenon. Gowers, *et al.*, (2010) in meta-analysis of psychiatric and psychological research state that 11 females to 1 male suffer from anorexia nervosa. The current version of the DSM IV states that 90% of the cases of anorexia nervosa are in females. This imbalance in numbers is unequivocal in demonstrating that gender is a major factor in the development of this particular phenomenon. It is really bizarre that the current trend in revising the DSM is to make the definition of anorexia nervosa gender neutral and that the data set of articles from 2009 in the psychiatric literature had so little research directly on gender.

In relation to the socio-cultural evidence present with the current DSM IV, there is recognition that anorexia nervosa is more prevalent in "industrialized societies" where "being considered attractive is linked to being thin" (*American Psychiatric Association*, 1994, p. 542) and that immigration into an industrialized culture increases the frequency of anorexia nervosa. Furthermore, the current version of the DSM IV accepts the idea that "Cultural factors may also influence the manifestation of the disorder" and result from the assimilation of "thin-body ideals" (p. 543). This position is further advanced in Becker, Eddy and Perloe, (2009) review for the revision of the DSM IV when they state that patient perceptions "reflect culturally embedded core values and notions about self-agency that influence the perceived feasibility and social desirability of managing weight" (p. 612). These researchers' position recognizes that the "pursuit of thinness" in the Western world involves the connection between identity, self and body and the belief that "individuals can exert control over their shape or weight" (p. 612). These researchers point out directly that diagnosis of anorexia nervosa to be conducted appropriately without understanding culture and that diagnosis needs to address the cultural context of the patient.

In a different DSM IV review paper, Becker, Thomas and Pike's (2009) discuss the different ways in which anorexia nervosa manifests itself in various non-Western countries. Furthermore, in the corpus of research articles in 2009 the largest category of research dealt

with socio-cultural influences on anorexia nervosa – mainly the role of different communities in supporting anorexia nervosa. Thus there is ample evidence of the relevance and importance of the socio-cultural context in the development of anorexia nervosa and yet within the core defining features of anorexia nervosa this is ignored.

Particularly revealing on this issue is the position statement from the Academy of Eating Disorders (an organization of the central psychiatric researchers involved in the revision of the DSM IV) published in the *International Journal of Eating Disorders* which states that anorexia nervosa is a "biologically based, serious mental illnesses" and that "eating disorders are significantly heritable; influenced by alterations of brain function; significantly impair cognitive function, judgment, and emotional stability; and restrict the life activities of persons afflicted with these illnesses" (Klump, et al, 2009, p. 97). The complete avoidance of any mention of either gender of socio-cultural factors by these researchers is astounding. This is especially troubling because the biological markers they specify in relation to anorexia nervosa can all be seen as results of self starvation rather than causes. This is not responsible scientific work but rather the result of disciplinary discursive preference.

The data actually seems quite clear that anorexia nervosa - the self starvation of predominantly young women in Western and Westernized countries – is a gendered, socio-cultural phenomenon. Without the discursive pressures of psychiatric discourse this empirical evidence would be the basis for continued research exactly along the lines of exploring how genders interacts with socio-cultural context to cause the phenomenon that young women starve themselves. It is incredible that this research is not being conducted by serious empirical researchers of the type that psychiatric discourse champions.

9.3. Art Therapy Ramifications

For the field of art therapy, the current study has several significant outcomes that need to be addressed as the ramifications of this study. Importantly, as argued above and seen in the analysis of both psychiatric and art therapy *materials* there is a need for the integration of gendered, socio-cultural understandings in the treatment of self-starving women. More broadly, and across the whole field of art therapy, there is a need to consider ways in which gender and socio-cultural contextualization impact art therapy practice. Finally, the issue of discursive self marginalization as a core aspect of art therapy needs to be considered. Accordingly this section will address: disciplinary discursive self marginalization; the integration of gendered, socio-cultural understandings into art therapy practice; and the importance of developing gendered, feminist, socio-cultural understandings of self-starving women for both the fields of art therapy and psychiatry.

9.3.1 Addressing Discursive Self-Marginalization in Art Therapy

As described in Chapter Eight, the field of art therapy is defined by the interaction of two discursive forces: the significance of art to the therapy process and the need to conceptualize the role of art in therapy by applying discursive understandings that come from adjacent disciplines and discourses. This description of disciplinary discourses in art therapy makes the field very susceptible to self marginalization and in a constant process of seeking approval from more powerful discourses and disciplines. Specifically as seen in this study of the discursive construction of the concept of anorexia nervosa changes in the field of psychiatry produced different explanations and ways of positioning art in the field of art therapy. The application of psychiatric discourse to explanations in art therapy does not seem to have happened as a result of changes in the field of art therapy or some form of interdisciplinary interaction but rather as a result of the acceptance of the authority of psychiatry in deciding on the way anorexia nervosa is explained. In other words, it is a result of acceptance of the power of psychiatric discourse.

While in the realities of institutionalized clinical practice, it is very difficult to negate, counter or even be seen to question psychiatric discourse from the position of being an art therapist, blind acceptance of the authority of this discourse is very problematic. Psychiatric discourse is produced along disciplinary discursive guidelines and as seen in this dissertation, can actually be explained in terms of a'priori discursive preferences. So much so that it may, as in the case of anorexia nervosa, actually ignore its own empirical results and produce statements that at best can be considered questionable science.

The power of art therapy is in the presence of art in the process of therapy. This is an agreed position across art therapists of different types. As such, various different discourses could be applied to the interpretation and understanding of the art work, art process and the state of the patient. There is a freedom in approaching the art work and process from this perspective. Rather than an ideological model which prefers the most powerful discourse at any given moment, a more rational process of decision and interpretation can be applied. In other words, a professional well informed art therapist can and should make decisions in relation to the ways in which art therapy is understood and practiced. For all sorts of reasons, psychiatric discourse might be chosen as a way of approaching therapy with a given patient. But the crucial issue is that the art therapist has made a professional choice based on the needs of the patient and her understanding of the profession and the various discourses that offer options of explanation.

Furthermore, it is necessary for art therapists to see through the illusion of the authority of psychiatric and other psychological discourses. While these may indeed be institutionally strong and verbally abusive in their war to guard the borders of knowledge, knowledge construction in psychiatry is based on disciplinary discourse and as such is questionable (as is every other type of knowledge construction). Art therapist need to recognize the value of their own research endeavours and seek out methods that allow valuable disciplinary knowledge within the realm of art therapy to emerge. Ironically, art therapy might be better suited at doing this than science mainly because of its more eclectic disciplinary discourse and because it works through the explicit evidence of produced art works and processes.

9.3.2 Integrating Gendered, Socio-Cultural Understandings into Art Therapy Practice

One of the outcomes of the discussion of anorexia nervosa within the fields of art therapy and psychiatry is the understanding of the way discourse has distanced and ignored obvious variables of gender and socio-cultural context in the definition of anorexia nervosa. There is a need to understand the role of gender and socio-cultural context in exploring phenomena such as self starving women. I would argue that the main barrier to the development of this understanding is the way in which psychological distress is understood and presented to art therapists. If psychological distress is situated in the individual and as a result of biological and personal characteristics, there is no room for interaction with gender or social-cultural discursive forces. Accordingly, there seems to be a need for a widening of the understanding the commonly referenced therapeutic triangle of art, patient-artist and therapist within the art therapy setting.

Within the psychodynamic art therapy literature (see Schaverien, 1999 for example) the art therapy process is explained through the processes of transference and counter-transference within the frame of the therapeutic triangle of art, patient-artist and therapist. These terms describe a process in which psychic material (whether conscious or unconscious) is interjected into the therapeutic session by both patient and therapist and in relation to the art process and product. As conceptualized within that literature this therapeutic triangle and the psychodynamic concepts of transference and counter-transference focus on the interaction among therapist, patient-artist and art work but limit the discussion of socio-cultural or gendered understandings.

The feminist therapist Laura Brown (2001), in line with feminist thought, proposes replacing the concepts transference and counter-transference with the term "symbolic relationship". According to Brown (2001) the symbolic relationship "for therapists consists of

the way in which the therapists' own feelings, responses, and reactions to a client as well as the manner in which they relate to and with that client are informed by context and personal life experiences in a continuous, interactive loop between internal and external realities" (p.1006). Furthermore, Brown (2001) describes that context as including "the meanings of the personal and cultural heritage and history of the therapist and client(s) alike", the ways in which "each person represents certain *social constructs* to the other" (p. 1006). According to Brown (2001) the "context that leads to the symbolic relationship includes events occurring in the here and now" (p.1006). Put simply, personal, gendered, social contextualization is consistently present within the therapeutic process and it is the context of both patient and therapist that constructs the symbolic relationship between them. Put another way, the therapeutic triangle is constituted within the specific gendered, socio-cultural discursive context of patient, therapist and art work.

This widened therapeutic triangle which integrates Brown's (2001) concept of symbolic relationship, replacing the concepts of transference and counter-transference, creates a theoretical basis upon which gender sensitive, socio-cultural informed art therapy can be explicated. Within this frame, the artistic process and product represents external and internal realities as well as the broader, underpinning discursive context which has informed many of the images that are used and produced. This art work embodies the discursive understandings that have informed its production and is an on-going dialectical relationship with other social and cultural representations (Hogan, 1997). Thus, the art process and the art work interposes personal discursive understandings into the therapeutic setting. The symbolic relationship occurs through the artistic representation which contains socio-cultural context, gender, lived experiences, personal meanings, cultural heritage and history and social discourse. The symbolic relationship takes place in the here and now through the visual representation that contains the internalized social and cultural constructs of both therapist and patient-artist. From an analytical perspective, for a feminist therapist the symbolic relationship is about "the meaning of the social markers that the client brings to the table of therapy" (Brown 2001, p.1006) and it is these that are the locus of the therapeutic interaction.

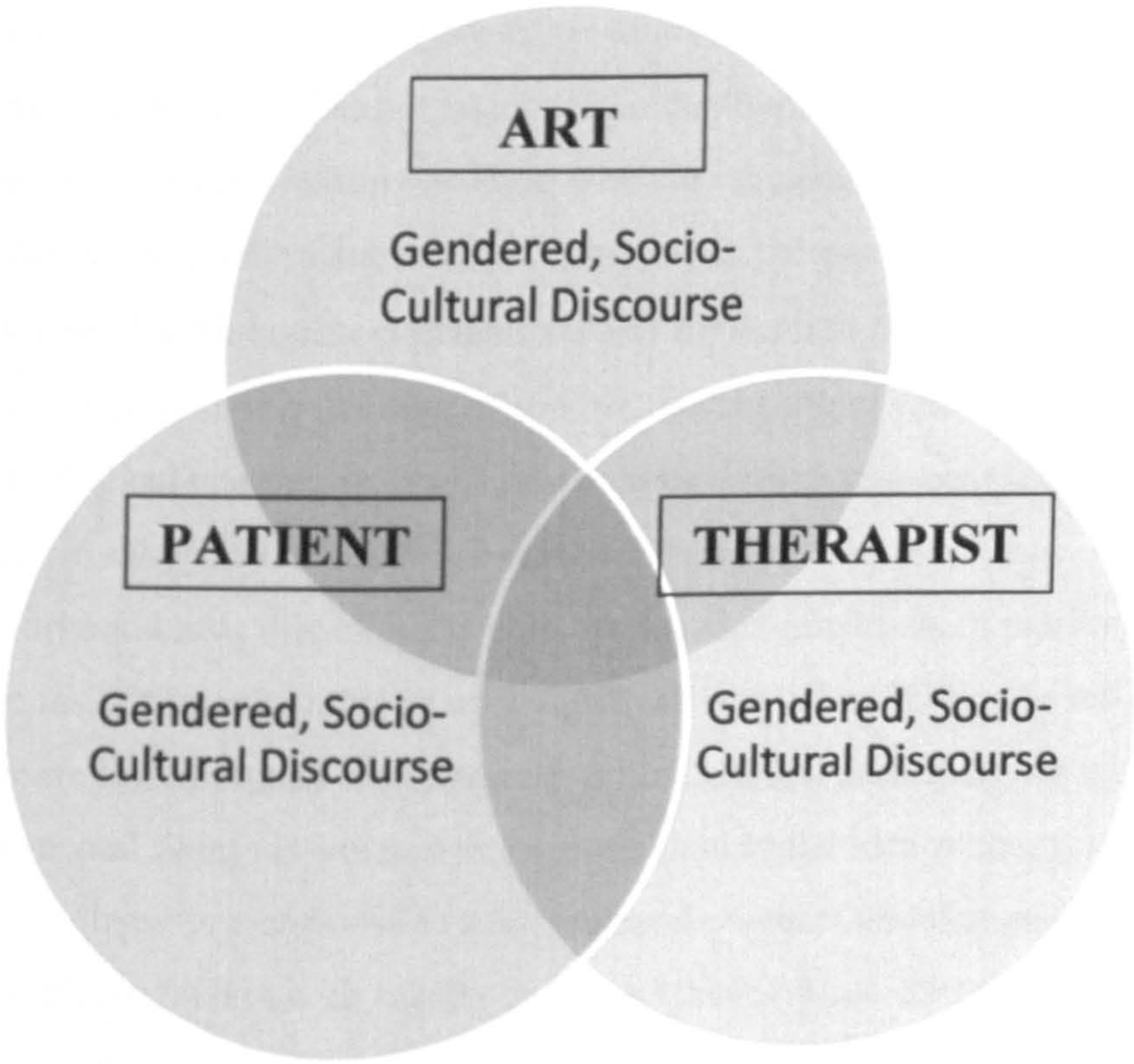

Figure 9.1 A Feminist Therapeutic "Triangle" of Art Therapy

As can be seen in Figure 9.1 each of the components of the original therapeutic triangle is fully situated within a discursive context that embodies gendered, socio-cultural understandings. The therapeutic triangle is not a free, uninterrupted space outside of the real world; but rather "the world exists in the therapeutic space" (Davis-Halifax, 2003, p. 41). Feminist art therapy involves exploring the multilayered, socio-cultural and gendered discourse which provides meanings for the produced visual representation. It is a process of coming to know the social environment and symbolic meanings that are manifest in the art work. Close consideration of the visual art work can reveal for both patient and therapist how gender is understood and performed in the world by the patient and the power relations and adjacent psychological outcomes manifest in this understanding. This can be a form of personal insight that involves the understanding of the normative roles of gender and its interaction with potentially oppressive social and cultural understandings, beliefs and behaviours.

9.3.3 Developing Gendered, Socio-Cultural Understandings of Self-Starving Women

The analysis of the discursive construction of the concept of anorexia nervosa in the disciplines of art therapy and psychiatry makes it clear that current disciplinary discourse distances gender and socio-cultural context as variables in the explanation of anorexia nervosa. Ironically the empirical evidence collected by psychiatrists and psychologists

suggests a very clear role for both of these as variables that need to be considered. It is interesting to consider why this has not happened in the literature. As seen throughout this dissertation a large part of the reason has to do with the way disciplinary discourse creates preference for particular types of statement. Concretely in the case of anorexia nervosa the main search has been for biological explanations and for explicit measureable evidence. Issues of gender and a full understanding of socio-cultural context would require a very different epistemological orientation, one that would be willing to accept cultural and feminist analyses. A range of methodologies that explore the phenomenology of being a woman in the world and how this interacts with the broader constructs of patriarchal society may allow some insight into the reasons why young women are so willing to self starve.

Furthermore this approach would require a fundamental shift from the medical assumption that mental illness is situated in the individual to the idea propagated in feminist circles that mental illness is a response to socio-cultural contexts and that gender is constructed through interaction with society and is not a biological construct (Hogan, 1997). This is basically a shift towards feminist understandings of psychological therapy. As summarized by Evans, Kincade, Marbley and Seem (2005) what all feminist therapies share is a "valuing of gender as a central organizing aspect in an individual's life and the tenet that an individual cannot be divorced from their culture" (p. 270). Feminist approaches to therapy situate the individual and their associated psychological issues on a very different basis than the one proposed in the psychiatric literature with its emphasis on the explicit evidence, biological etiology, and the situating of mental illness in the individual. From a feminist perspective mental illness is gendered and contextualized and evolves in interaction with societal, discursive forces (Hogan, 1997, 2003).

A core understanding of the women's mental health issues is that women's social and psychological position are interrelated and influence one another. As argued by the feminist art therapist Davis Halifax (2003) "the inner life of an individual cannot be treated without the understanding that she developed in an oppressive culture; one which views her as inferior and deficient" (p.34). Historically evidence has shown that socially and culturally women were marginalized and oppressed, in society, in their own homes and that this influenced women's emotional life, mental health and well being (Hogan, 1997). Put simply, issues of power have psychological effects. The feminist therapist Laura Brown (2006) clearly makes this connection when she explicates the concept of the "politics of the personal" as an exploration of the "experiences of power and powerlessness in people's lives, experiences that interact with the body and biologies we bring into the world to create

distress, resilience, dysfunction, and competence" (p. 17). Feminist therapy addresses power relations reflected and directed through societal discourses precisely to enact changes in the psychological world of the individual. Rather than seeing psychological distress as biological and individual it is situated within the power and discursive structures which constitute and inform the client's way of being in the world.

As documented in this dissertation in relation to the concept of anorexia nervosa and more broadly in the array of feminist and critical literature dealing with the history of women and therapy up until the 1960's, traditional psychotherapy has on the whole not been supportive of women, was explicitly based on masculine assumptions and suffered from a lack of social and cultural perspectives (Israeli & Santor, 2000). As documented in this dissertation in relation to anorexia nervosa, recent developments in the 21st century have changed the situation only in that gendered assumptions have been obscured in the language of instrumental approaches and political correctness while the role of gender and social-cultural contextualization is still ignored. Accordingly, the challenge is that all those involved in the treatment of self starving women is to really address the evidence which suggests that anorexia nervosa is a gendered, socio-cultural phenomenon and finds appropriate methodologies to really understand what this actually means. There is a clear need for a feminist, socio-cultural approach to the understanding of self-starving women. In the final chapter of this dissertation, I will develop one theory that attempts to capture this understanding and way of constructing self-starving women.

9.4 Limitations

As with any study, the current dissertation has its limitations. The current research project used a critical discourse analysis approach to a collected corpus of academic materials in the fields of art therapy and psychiatry. As such, this project and its conclusions are sensitive to the type of data collected and the type of analysis that was conducted. The literature on anorexia nervosa within psychiatry is very large and it was impossible to analyse the full corpus. As such decisions were made that limited the corpus to three journals and one year (2009), the DSM IV and review papers concerning the revision of the DSM. No doubt many more research articles exist. Thus the conclusions reached may be limited to the particular corpus that was studied.

However, the choice to look at the DSM IV and the proposed revisions for the DSM V has more generalizability in that these are central documents that are widely referenced in the understanding of anorexia nervosa. One limitation here is that the DSM V has not yet been published and the conclusions concerning the 21st century in this dissertation are based

on the proposal for changes rather than the changes themselves. Having said that, the broad historical directions do seem to be clear and I will be very surprised if the next version of the DSM V does indeed break with the discursive Neo-Kraepelinian guidelines and includes gendered, socio-cultural understandings of anorexia nervosa as a central aspect of its definition.

The corpus of materials that addressed the disciplinary construction of anorexia nervosa in art therapy was more comprehensive and as such it is easier to reach conclusions on the basis of this study. Furthermore, this dissertation presented both in-depth individual studies of each of the papers and a broad, historical discursive overview of these materials. But as with any discourse analysis there are different ways in which verbal texts can be understood and interpreted. I have tried to be honest and transparent in the way these texts were addressed and hopefully this alleviates some of the concerns in relation to this type of study.

A final limitation is that this study was constituted from a *specific epistemological* and ideological orientation. This is also true of every study but not always stated explicitly. My orientation is feminist and involves a poststructuralist research methodology. This has allowed me to construct a genealogy of the concept of anorexia nervosa in psychiatry and art therapy but for some this type of approach may seem suspicious in that the data consists of collected documents and the analysis does not lend itself to positivist positions on falsifiability.

Chapter Ten

Postscript:

Towards a Socio-Cultural, Gendered Theory of Self Starving Women

10.1 Situating the Proposed Theory

One of the main ramifications of this dissertation was the need for a gendered, socio-cultural understanding of self-starving women. In this last chapter, I will present a provisional theory of what this type of explanation would involve. This chapter is not a summary of the positions found within the exploration of ways of *constructing* anorexia nervosa found in the current literature of art therapy or psychiatry but rather a response to it and to the need to develop this direction in research. As such this chapter is termed a postscript as it involves a movement beyond the bounds of the original study of the discursive construction of anorexia nervosa. But I consider this chapter of importance as I have spent the last five years thinking very carefully about how I understand and explain the phenomenon of self starving women and have been unsatisfied with the answers I have read so far. I agree with my own conclusion that a gendered, socio-cultural approach is needed and this means embracing theoretical and feminist understandings of the female condition. As such this is a personal attempt to explore how anorexia nervosa could be *understood from a very different* discursive starting point than that of psychiatry (with its inherent limitations).

The basic approach to understanding self-starving women is to see this behavior within a gendered, socio-cultural context and to situate self-starvation as a response, strategy or solution to gendered positioning within society. While this position could be assigned to any form of psychological distress, there are specific reasons why this is particularly suitable for addressing anorexia nervosa. Foremost of these is the statistical information that the vast majority of individuals who self-starve and are diagnosed as suffering from anorexia nervosa are women, mainly in adolescence, and that these women tend to come from Western or Westernized societies (Gowers, et al., 2010). Accordingly, the statistical evidence of the clinical presentation of anorexia nervosa would suggest that this is very much a gendered and socially and culturally contextualized phenomenon. Thus, a feminist approach which looks directly at the gender within a socio-cultural context seems very suitable.

Second, if the phenomenon of self starving women *within Western and Westernized* countries is conceptualized as a response to gender positioning within socio-cultural discourse, the question that needs to be posed is what exactly within this context is being responded to. A feminist approach suggests that psychological distress is a response to particular sources of oppression and experiences of powerlessness. Accordingly,

understanding and treating *self starving women* involves addressing the particular aspects of societal discourse that produce the response of self starvation in women.

Accordingly, the main aim of this chapter is to develop a gendered, socio-cultural understanding of the phenomenon of self starving women termed in the medical literature *anorexia nervosa*. In other words, this section is an attempt to answer the question, posed above, *what exactly within the socio-cultural, discursive context produces a response in which predominantly young women are willing to endanger their physical existence through self starvation*? As a starting point, this theory will avoid the term anorexia nervosa and prefer the term self starving women. As seen throughout this dissertation and in the work of Malson (1998) anorexia nervosa is a historical disciplinary term which constructs the phenomenon of self starving women as an individual disorder with roots in biology, family history or personal pathology. Self starving women is not a medical term and provides just a basic description of the phenomenon itself – i.e. that certain women starve themselves. The use of the term "self" within this designation is an accurate description of what occurs; however, as will be seen in the coming discussion "self" starvation does not assume decontextualized individual volition for the term self. Quite the opposite is true; the actual challenge of understanding self starving women is to explain what forces would make someone starve themselves. In other words, the core of a theory of self starving women is to explain on a gendered, socio-cultural level how discourse could construct a gendered self that would willingly enter into a process of starvation.

10.2 Understanding Female Consciousness: A Review of Bartky (1990)

In order to construct this provisional theory of self starving women, I will return to Foucault's theoretical positions and critiques of Foucault's work from a feminist perspective. Foucault (1977) is particularly useful in constructing a socio-cultural understanding of self starving women in that he developed a sophisticated theoretical position on the relationship between power, modernity and the body. However, as stated by the feminist phenomenological philosopher Sandra Lee Bartky (1990), Foucault is problematic in that his theory of the body did not differentiate between male and female bodies and the associated ramifications of this socially constructed, discursive and gendered differentiation. Thus, the theory developed here is based in Foucault's (1979) understanding of the discursive construction of the body and Bartky's (1990) critique and extension of this theory from a feminist perspective.

In Foucault's (1979) *Discipline and Punish,* through a discussion of the particularly regimented forms of social organization such as the prison, Foucault makes the point that

Western modernity utilizes a wide range of discursive practices designed to produce what he terms as "docile bodies" (p. 138). In other words, the power of modernity is directed at controlling and regulating the body of individuals. This regulation of the body is extensive and directs the form of the body, the movements of the body and the temporal aspects of bodily function. As analysed by Foucault (1979) in the disciplinary practices of schools, factories and prisons, the body is rigidly controlled with specification of the form and presentation of the body and obligatory detailed actions, in particular sites and at specific times. The main manifestation of the micro-management of power is in relation to the strict regulation of bodily existence.

Significantly, for our purposes in this dissertation, for Foucault (1979) the control of modernity is not only enacted through external regulation of the body but rather through a process of the construction of self-regimenting consciousness in the individual. As represented in the discussion of the Panopticon – a design of a prison in which a central tower surrounded by a circular construction of individual prison cells with wide windows allows a central supervisor to observe each cell's inhabitant consistently – Foucault (1979) points out that the aim of the design is to "induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power" (p. 201). Thus, modernity constructs a situation in which the individual self-regulates his actions as a result of the consciousness and knowledge of his consistent visibility. For Foucault (1979) this is not just a phenomenon of prisons but permeates throughout modern society. This understanding changes the conception of the individual; in modernity, enhanced self-consciousness – the central aspect of being an individual - is not a source of freedom from socio-cultural restraints but rather is source of self regulation directed through the knowledge of consistent externally constituted observation and specification of bodily existence. We become prisoners of our own self-conscious regulation of our bodies.

Bartky (1990) in the attempt to define feminine consciousness critiques Foucault for not addressing "the disciplinary practices that engender the "docile bodies" of women, bodies more docile than the bodies of men" (p. 65). This oversight is significant in that the subjugation of women's bodies through a variety of discursive practices is not only different from that of men but also constructs a different form of consciousness. Bartky's (1990) feminist analysis is designed to elicit and explicate the nature of this feminine consciousness and its source within practices of regulation of the feminine body. As defined by Bartky (1990) her aim is to "examine those disciplinary practices that produce a body which in

gesture and appearance is recognizably feminine" and then "probe the effects of the imposition such discipline on female identity and subjectivity" (p. 65).

Bartky's (1990) analysis of body producing disciplinary practices draws upon a range of common, prevalent body modification practices many of which (if not all) have become normalized to the extent that they seem mundane. These include the pervasive mass media messages concerning the correct body type in relation to all aspects of the body from hair to toes and everything in-between; dieting behaviors constituted within the discourse of the "tyranny of slenderness" (Chernin, 1981); women's exercise patterns; cosmetics and beauty requirements mainly focused on the face but including a wide range of other body parts such as the removal of hair from legs, arms and pubic areas to specification of types of nail polish. Furthermore, Bartky (1990) draws upon research into positioning and movement of the female body. Referencing research on personal space, movement and gesture, Bartky (1990) describes woman's space as more limited than that of men, their gestures more restricted, their eyes directed downwards in deference, their posture more constricted, and their bodily movements through space directed by a subtle male hand. Finally, Bartky (1990) points out that the "woman's body is an ornamented surface" over which there is extensive disciplinary control: hair must be removed through shaving, wax or electrolysis; eyebrows plucked; skin cleansed; skin tone evened through cosmetics; skin hydrated; nails manicured and pedicured; hair blow dried, brushed, dyed, curled, straightened or manipulated in a variety of ways; lips painted; eyelashes lengthened and darkened using mascara; eyelids coloured; cheeks blushed and this is only a partial list of the ways in which women ornament their bodies. In short there is an extensive list of everyday, common place practices through which women on a daily basis and throughout their lives discipline, regulate and aim to change and restrict their bodies so as to conform to accepted and propagated forms of the feminine body.

This analysis presented by Bartky (1990) is supported by more recent work with the framework of sociology under the heading of "body work" (Gimlin, 2002, 2007). The underpinning assumption of this work is that society directs bodies to be constructed as cultural artifacts. However, as stated by Gimlin (2007) not all bodies are equal and more subjugated groups are required to extend more time and effort in regulating and disciplining their bodies. Specifically, women as one of these subjugated groups, are "expected to engage in a larger number of body management practices, spend more effort and money on them, and be more concerned about them than men" (Gimlin, 2007, p. 355). Thus, as argued by Bartky (1990) the construction of the feminine body is not just different from that of men but rather it designates and manifests the inferior status of women.

For Bartky (1990) underpinning the extensive body work required of women and conducted by women is a pervasive, discursive message of bodily deficiency. The prevalent and widely propagated understanding is that female bodies are inherently problematic and as such require extensive daily and hourly work in order to attempt to overcome their insufficiencies. Cosmetics, cosmetic surgery, exercise, dieting and fashion are, within this analysis, all techniques of disguise designed to transform and modify the body so that it hides its 'natural' deficiencies and 'ugliness'. Tied directly to this sense of deficiency is an inherent sense of shame at not being able, ultimately, to overcome the problems of the female body. As noted by both Bartky (1990) and Gimlin (1994) this is a trap in that the discursive requirements of the feminine body are contradictory, unattainable and unsustainable. Thus women are constantly trying to manage their bodies and face the ever-present potential for feeling shame over their inability to do so.

This discursive message of body deficiency and its associated sense of shame are themselves part of a broader and deeper discursive context which defines the constructed inferiority of the female body. As argued by Bartky (1990) the more pervasive and *underpinning discursive context is* the construction of the relationship between men and women with the later requiring acceptance from the former. *In other words, this is a* discourse in which women are constructed as in need of "male patronage" (Bartky, 1990, p. 76). This is a discourse which constructs men as the judges of women. The understanding is that this patronage is tied directly to a particular vision of the feminine body. The closeness of the appropriation of the ideal of the feminine body (whatever that may be at different times) infers social acceptability and the possibility of success and as such becomes the aim of women with the wider purpose of reaching acceptance. In this formulation, all practices of feminine body regulation and modification fulfill the aim of attaining male patronage which brings with it (a limited degree of) power, prestige and success.

However, it is a mistake to think that this social meaning of the feminine body is sanctioned externally. While there is extensive evidence that women face a range of informal comments about their appearance and are directly aware of the social ramifications of not conforming to idealized versions of the feminine body, most importantly this is an internal, self regulated activity. As argued by Bartky (1990) in a gendered extension of Foucault's discussion of the Panopticon: "In contemporary patriarchal culture, a panoptical male connoisseur resides within the consciousness of most women: They stand perpetually before his gaze and under his judgment. Woman lives her body as seen by another, by an anonymous patriarchal Other" (p. 72). In other words, there is a process through which

patriarchal gaze is internalized and becomes part of the consciousness of the individual woman dictating a particular way of seeing and constructing the body. Thus, the practices of female body modification flow directly from an internal patriarchal gaze of the way the feminine body should be and are situated in the discursive self positioning that needs and aims for approval and patronage from a male Other.

A central aspect of this internalized patriarchal Other and the requirement for a particular feminine body is the paradox of achieving control and attaining identity. The internalized patriarchal Other and the specification of a feminine body offer the option of a "secure sense of identity" and more importantly for this dissertation, knowledge of the practices of body modification offer a "sense of mastery" in achieving male acceptance (Bartky, 1990, p. 77). The paradox is that while conforming to an ideal of a particular feminine body and situating oneself as judged by a male gaze involves disempowerment, subjugation and inferiority, the mechanism for achieving male acceptance – the practices of body modification – provides a sense of control and achievement. The paradox is that the way of achieving much broader social and discursive disempowerment for women provides a clear sense of personal mastery and control; disempowerment is achieved through a sense of personal control and mastery.

On an even deeper level, as pointed out by Bartky (1990) to "have a body felt to be "feminine" – a body socially constructed through the appropriate practices – is in most cases crucial to a woman's sense of herself as female" and to "her sense of herself as an existing individual" (p. 77). In other words, the female body as defined through the internalized discourse of a patriarchal gaze has become the core tenet of personal identity. A woman is her body and the practices of body modification are the mechanisms of maintaining this feminine identity. Without conducting these practices of female body modification, a woman faces loss of identity, a form of annihilation. Thus, the practices of body modification become practices of personal discursive survival.

Overall, Bartky's (1990) aim in entering into an analysis of the feminine body was to explore the ramifications of this socio-cultural, discursive context on the construction and constitution of female consciousness. Within this analysis, female consciousness takes on very specific characteristics. Female consciousness is characterized by "obedience to patriarchy" expressed through a "relentless self-surveillance" of every aspect of her bodily being (Bartky, 1990, p. 80). Furthermore, female consciousness is different from male consciousness in that woman are aware that "*she* is under surveillance in a ways that *he* is not, that whatever else she may become, she is importantly a body designed to please or to

excite" (Bartky, 1990, p. 80 italics in the original). Central to understanding female consciousness is the concept of an internalized patriarchal gaze tied to particular definitions of the feminine body. This internalized patriarchal Other makes a woman into a "self-policing subject" subjugated to attaining male acceptance through the presentation of an unattainable body. Extensive and continual body modification is the inevitable outcome of this consciousness and paradoxically is the site at which temporary feelings of mastery and control can be attained. So deep rooted is this consciousness that the attainment of the feminine body has become the most basic aspect of being a woman and any suggestion of change to the regime of bodily modification can be seen by women as a threat to existence. Thus patriarchal power manifest in this deep rooted female consciousness ensures the status quo of an inherently oppressive power structure through the imposition of particular conceptions of the feminine body and women express their inferiority (but also paradoxically their sense of mastery and identity) through practices *designed to control and change* their bodies.

10.3 A Theoretical, Gendered, Socio-Cultural Theory of Self Starving Women

While Bartky's (1990) analysis of female consciousness is theoretical and philosophical in nature, the evidence for its reality is all around us with women engaged in extensive disciplinary practices of body modification and suffering acute psychological distress when the required body ideal is not achieved. Against this theoretical backdrop of female consciousness it is worth returning to our main aim in this section, a theoretical explanation of self starving women. As stated above, the actual challenge of understanding self starving women is to explain what forces would make someone starve themselves. In other words, the core of a theory of self starving women is to explain on a gendered, socio-cultural level how discourse could construct a gendered self that would willingly enter into a process of starvation.

In answer to this question, the concept of female consciousness developed by Bartky (1990) offers some insight. On a basic level, starvation is a more extreme form of a well known and widely used body modification practice – dieting. Like other body modification techniques the aim of dieting is to overcome the inherent problems of the female body and to make it conform to externally sanctioned and internalized concepts of the appropriate feminine body. The aim of dieting, as conceptualized within the theory of female consciousness developed above, is to attain a degree of power through movement towards an ideal of the feminine body and thus acceptance of male patronage. Thus, the practice of

dieting is the attempt to attain power through the disciplinary practice of body modification directed by a female consciousness in a patriarchal world.

Since female consciousness involves the internalization of a male Other, dieting is a self regulated process. The manifestation of dieting involves high degrees of self surveillance, control of food intake, a regime of exercise to burn calories and consistent body checking. Dieting is a practice that requires extensive time and resources. It is a constant battle with the most basic of physical needs - bodily hunger - and is a battle that is waged through the control of food intake, increased exertion and hunger repression. As specified by Bartky (1990) the practice of body modification is a set of skills that are learnt and infer a sense of mastery and control. Thus the actual practice of dieting with all its related techniques of body modification brings with it feelings of control and the ability to construct a more powerful self. Since the control of hunger is so difficult, the ability to perfect this particular ability infers a high degree of mastery and control over the body. In this sense, the ability to diet is a real measure of success and a self-regulated and self-imposed bodily modification practice designed to increase a personal sense of power through the attainment of a feminine body (which by association includes the option of male patronage). Dieting is, thus, a method for achieving the aim of male patronage (and hence a degree of power); but as a self regulated and self imposed method it can produce personal feelings of mastery and control.

So far the analysis has not explained self starving women but merely the more mundane, and widely utilized practice of women dieting. Self starvation is more than just an intensification of the body modification practice of dieting, it involves a significant qualitative difference. The self starving woman does not just diet, in effect she over-diets. So much so that the original aim of dieting – to achieve a feminine body and thus male patronage – is contradicted. The body of the self starving woman is not that of a feminine body. *It is an emaciated, withered body* moving towards death. In other words, at some point the nature of the body modification mechanism - dieting - changes *and it is this change that* makes the situation of the self starving woman life threatening. Even a superficial understanding of the behavior of a self starving woman makes it clear that the behavior of self starvation and the preoccupation with controlling nutrition intake has become the single most important aspect of that woman's life. In other words, it has become an aim in itself. Thus the significant qualitative shift that has occurred is that instead of dieting being a method designed to achieve the aim of a feminine body and thus a sense of power through the option of male patronage, dieting in itself has become the single most important aim. Self

starving women see dieting as the aim of their lives. Their consciousness is filled with achieving this aim.

Underpinning this shift from dieting as a method for achieving male patronage (through attainment of a feminine body) to an aim in itself, is the desire to attain a degree of personal power and overcome the inherent feelings of powerlessness situated in female consciousness. As rightly pointed out by Bartky (1990) the disciplinary practices of body modification infer a sense of mastery and control. They are a set of skills that must be mastered and can be valued in themselves. In fact without even approximating the ideal feminine body the process of moving towards that ideal through bodily disciplinary practices elicits positive responses from the surroundings and an increased sense of success, control and power. At some point in dieting, the self starving woman becomes convinced that power can be achieved through the disciplinary practice of *continual* dieting. In other words, the actual practice of self regulated and self imposed dieting brings with it an increased sense of personal power without this necessarily leading to a more feminine body. In fact, it is a much more direct root for achieving power as the measure of success is the ability to practice dieting and is self controlled and regulated. Ultimately, when the dieting leads to the outcome of self-starvation and authorities and families are involved, the manifestation of the power of this disciplinary bodily practice becomes even more apparent. The self starving woman sees her power, mastery and control in the ability to draw attention to herself and reject the suggestions, demands and pleas that she eat. Through dieting she seems to herself to have become powerful.

It is important to understand that this shift towards seeing the practices of dieting as an aim occurs within female consciousness in which male rejection, the loss of male patronage and the associated danger of powerlessness, is ever present. The aim of feeling the greatest degree of power is still the central issue for the self starving woman. Accordingly, any attempt to stop the self starving woman from continuing her dieting behaviors or even the slightest increase in weight is seen as a direct attack on the main source of this woman's way of achieving power. The continuing presence of a female consciousness manifests itself in the ever present fear of fat that designates within this patriarchal discursive system loss of male patronage. Broadly, the self starving woman avoids or distances any of the actions or interactions which will decrease her new found sense of power from the achievements of her dieting practices. Accordingly, some self starving women after a while begin to avoid society and their families while continuing their practices of extreme dieting and exercise. They not only self regulate their bodies and restrict their intake so as to achieve a sense of power; they

also restrict potentially negative social interactions which could decrease their sense of achievement and success at dieting. Thus, self starvation and the physical body it produces exist simultaneously with the original precepts of female consciousness - the acceptance of the feminine body. But self starvation offers a double solution to the way women are positioned in female consciousness: 1) The bodily practices involved in dieting produce feelings of enhanced power, mastery, control and success; & 2) the body produced by dieting avoids the ridicule and rejection associated with weight.

For self starving women dieting behavior, as an aim in itself, can become concretized as a form of successful self-identity. As pointed out by Bartky, (1990), Gimlin (1994) and Maclagan (1998) the ideal of the feminine body is ultimately impossible to attain. Achieving the ideal of feminine bodily beauty is not actually possible. Thus the feminine body within female consciousness brings with it an identity *that is inevitably* full of shame and disappointment. Self starving women still deeply wish to fulfill the dictates of the internalized patriarchal Other and become the feminine body. According to Gimlin (1994) they "overconform" to this ideal of female beauty and pursue thinness to its ultimate conclusion. But the impossibility of reaching the ideal feminine body means that a woman is constantly faced with her own sense of deficiency. Self-regulated dieting, on the other hand, comes with very clear guidelines of success and markers of achievement. It is within the realm of the individual to fulfill the self-prescribed and self-regulated guidelines of dieting practices. The difficulty of these practices makes success even sweeter and makes the actual behaviors desirable because of their outcome in defining her success. As such, the success of dieting becomes an identity just like a star athlete would define themselves according to their achievements. Thus, paradoxically the self starving woman still within the confines of female consciousness sees the body modification *practices of dieting* as the central aim of her life (although it will ultimately kill her if she continues) and as her identity as a successful individual (even though the body it produces contradicts the feminine body). The movement of dieting behaviors from method to aim; the experience of dieting as a means of achieving mastery, control and power; and ultimately the transition of the behaviors of dieting into a desired personal identity define the self starving woman who will kill herself through her practices – an unrelenting perfection of dieting behaviors.

Within the range of existing socio-cultural theories of self starving women, the current theory is closest to the position taken by Gimlin (1994). I agree with Gimlin (1994) that self starving women "overconform" to the ideal of feminine beauty and that this is manifest by "practicing extreme control over her body" (p. 108). As stated by Gimlin (1994)

"the anorexic fills the female role perfectly" (p. 108). In the terms developed here, the self starving woman has fully internalized the need for body modification practices as dictated by the internalized patriarchal Other. I also agree with Gimlin (1994) that previous gendered socio-cultural explanations of anorexia *nervosa which* situate anorexia nervosa as a protest or a rebellion against male domination (see Bell, 1988; Bordo, 1985; Orbach, 1986) are problematic in that they do not capture the ultimate compliance within female consciousness of male dictates that is present within the act of extreme dieting. Furthermore, I agree that positioning the self starving women as a martyr (see MacLeod, 1981; Millman, 1980) romanticizes the real suffering of these women.

I differ from Gimlin (1994) in the way the actual practice of dieting is understood. The position developed here based on the analysis of female consciousness developed by Bartky (1990) recognizes the potential of mastery of bodily modification practices as a source of personal power. In other words, while Gimlin (1994) positions overcomformity to the ideal of female beauty as an extension of women being passive, helpless and dependent; the theory developed here sees the transformation of the practices of dieting from a method into an aim as a source of power. The hold of dieting practices over the consciousness of the self starving woman is based on the ability of these practices to provide the self-regulated sense of control *and mastery. In this sense,* it is the ultimate solution to the contradictions of female consciousness: you cannot achieve the aim of a feminine *body with any feeling* of success even though you desire to do so; but you can be the perfect practitioner of bodily modification.

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